

# HEW ADMINISTRATION OF THE PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO) PROGRAM

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## HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT OF THE COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES NINETY-FOURTH CONGRESS SECOND SESSION

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## CONTENTS

	Page
Panel of witnesses from the Department of Health, Education, and Welfare—	
Dr. Louis Hellman, Administrator, Health Services Administration; Dr. Michael Goran, Director, Bureau of Quality Assurance; John O'Rourke, Deputy Director, Office of Quality Standards, Office of Assistant Secretary of Health; and Thomas Tierney, Director, Bureau of Health Insurance, Social Security Administration-----	3
Statements submitted for the record—	
American Optometric Association-----	25
American Physical Therapy Association-----	25
American Occupational Therapy Association, Inc-----	26
American Psychological Association-----	28
Appendix—	
HEW responses to questions on PSRO program-----	31
Professional Standards Review Organizations responses to questions concerning experiences with HEW's administration of PSRO program -----	40

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FRIDAY, MAY 21, 1976

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON OVERSIGHT,  
COMMITTEE ON WAYS AND MEANS,  
*Washington, D.C.*

The subcommittee met at 10 a.m., in the committee hearing room, Longworth House Office Building, Hon. Charles A. Vanik (chairman of the subcommittee) presiding.

Mr. VANIK. The subcommittee will be in order.

I would point out at the outset we might be confronted with a quorum, but I thought we would get started and utilize all the time we have.

At the suggestion of the Health Subcommittee, we will be conducting a series of hearings on the PSRO (professional standards review organization) program. It is our intention at this hearing to examine the administration of the program. Subsequent hearings will examine other areas of the program and will involve nongovernmental witnesses who are active in the implementation of the program at the local level.

The PSRO program was created by the Congress as part of the Social Security Amendments of 1972, Public Law 92-603. Our purpose today is to examine what progress has been made in the implementation of this program since its inception 3½ years ago, and to learn what has to be done to insure that the program will be successful in reaching its long-range goals.

The PSRO program is designed to make certain that services provided to patients under medicare, medicaid, and the maternal and child health programs are medically necessary, are provided in accordance with professional standards, and in the case of institutional services, are rendered in the most appropriate setting. Congress reason for creating such a program was twofold: to insure that quality care is delivered to these patients and to slow down rapidly rising health care costs. In the course of the subcommittee's hearings, we would like to discover if the program is accomplishing these objectives. Indeed, we would like to discover whether the congressional expectation that PSRO's could hold down costs was reasonable, since improved quality of care is often incompatible with lower costs. If the congressional goal of holding down costs through PSRO's is not reasonable, then we must give renewed attention to finding other types of cost controls.

We believe that a great deal of attention needs to be given to the quality of administration of this program at HEW. The subcommittee has received a great deal of comment that lack of congressional appropriations caused the major implementation and administrative delays. Did the Congress fail to provide adequate appropriations? Lest we forget, I would like to quote from the House Appropriations Committee report for fiscal year 1975 :

The Committee approved 50 of the 175 new positions requested to administer the PSRO's. The testimony presented in the hearings is confusing as to the total number of people currently involved in this effort and the division of responsibilities among the various agencies of the Department is unclear. The Committee received information as late as May 28 to the effect that none of the 1974 funds available for PSRO contracts had been obligated as of that date. It appeared to the Committee that there is considerable slippage in the program \* \* \*.

From communications the subcommittee has received from PSRO's, it is not clear that the situation is fully improved. Now, however, PSRO's have also been given backdoor funding through the medicare trust funds and many of the funding problems may be resolved. But the program is not escaping oversight; we have the same concerns about the quality of administration that the Appropriations Committees have had, and we will be conducting prolonged oversight on this issue. However, I would like to say that we have received many fine compliments about the personnel at BQA.

The subcommittee is concerned that the program's implementation has been long delayed, but we are most concerned, at this point, in focusing on what can be done to prevent delays in the future. For example, the regulations that govern the program are not out yet. This is the second medicare program that was created by the 1972 Social Security Amendments which the Oversight Subcommittee has examined. Both programs, after 3½ years, are still without final regulations. We would like to know what the reasons are for this. We would also be interested in learning whether there are any other medicare programs which were created by Public Law 92-603 that are still without final regulations.

Another concern is that the data which would be available from a nationwide system of effectively operating PSRO's would provide invaluable information in defining what is malpractice and helping to end the present malpractice uncertainty. PSRO data could help insure the rapid spread of the most efficient quality modes of treatment throughout the Nation. At the same time, the data collected by PSRO's could raise the most sensitive confidentiality issues. This is an area which the subcommittee will study in an effort to insure the proper mix of public data and private confidentiality.

Other areas of the PSRO program with which we are concerned are such other issues as delegated review (we would like to know what checks exist to insure that the reviews that are delegated to hospitals are effective) and the involvement of other health care practitioners (what role do other health care practitioners presently play in the PSRO program; that is, optometrists, dentists, and nurses).

Previously, and I address this to the Department representatives here, we submitted questions to you. We appreciate your answers. We are submitting these exchanges for the hearing record. I would like to introduce our witnesses from the administration :

Dr. Louis Hellman, Administrator, Health Services Administration; Dr. Michael Goran, Director, Bureau of Quality Assurance; Mr. John O'Rourke, Deputy Director of the Office of Quality Standards within the Office of the Assistant Secretary of Health; and Mr. Thomas Tierney, Director, Bureau of Health Insurance, Social Security Administration.

Gentlemen, I appreciate your appearing before us today. We generally like to operate in a panel format. However, if anyone has a statement they wish to enter into the record, they may do so now.

**STATEMENTS OF A PANEL CONSISTING OF DR. LOUIS HELLMAN, ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION; DR. MICHAEL GORAN, DIRECTOR, BUREAU OF QUALITY ASSURANCE; JOHN O'ROURKE, DEPUTY DIRECTOR, OFFICE OF QUALITY STANDARDS, OFFICE OF ASSISTANT SECRETARY OF HEALTH; AND THOMAS TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION**

Mr. VANIK. I understand that you are leading off, Dr. Hellman. We would be pleased to hear from you at this time.

Dr. HELLMAN. I would like to apologize to you first that I have to leave by 12.

Mr. VANIK. There is no need to apologize for that. We will all have to leave by 12, and we will cooperate to that extent.

I want to call some attention to the fact that this afternoon you are going to be sworn in as Administrator of Health Services Administration.

I want to congratulate you on this full assumption of responsibility. We wish you well in your new work.

Dr. HELLMAN. Thank you, Mr. Chairman. I have a fairly short statement which I would like to read.

I am grateful for the opportunity to appear before the subcommittee this morning to discuss with you the status of the Professional Standards Review Organization program—PSRO.

I appreciate the efforts of this subcommittee toward appraising the progress of the PSRO program and helping to identify any problem areas which may exist. Today I think we can give you an encouraging report.

The PSRO program represents a significant effort by Congress and the Department of Health, Education, and Welfare to assure that the medical care provided to beneficiaries and recipients of the medicare, medicaid, and maternal and child health and crippled children's services programs is of high quality and that such care is provided in a manner which reflect the most appropriate and efficient utilization of our Nation's health care resources.

I would like to first recall the background of the program and the concepts embodied in it by the Congress at enactment, and then outline some of the progress made by the PSRO program since then.

The PSRO program was authorized by the 1972 amendments to the Social Security Act. The PSRO provision of Public Law 92-603 required the Secretary of HEW to establish and support a nationwide

network of voluntary, nonprofit groups of local physicians called professional standard review organizations.

These organizations were designed, first, to improve the quality; and second, to make more cost effective the over \$25 billion in Federal expenditures for health care services financed by and provided to beneficiaries and recipients of titles V, XVIII, and XIX of the Social Security Act.

The program is based on the concepts that health professionals are the most appropriate individuals to evaluate the quality of medical services and that effective peer review at the local level is the soundest method for assuring the appropriate use of health care resources and facilities.

The PSRO legislation was developed in response to the belief that increasingly high medical costs under Medicare and Medicaid were due in part to inappropriate utilization of institutional services.

It had become apparent that the then existing review mechanisms were ineffective in controlling unnecessary utilization or assuring that quality care was delivered.

These quality and cost concerns exist in even greater measure today as more documentary evidence becomes available on the delivery of poor quality or unnecessary health care services.

In 1972, legislators looked to a mechanism which could simultaneously improve quality while containing costs by preventing unnecessary use of services.

Beginning in the late 1950's, reports began to emerge which documented the successful efforts by relatively new physician review organizations to control unnecessary utilization of services and thereby control expenditures for services.

Some of these were EMCRO's, or experimental medical care review organizations, funded by HEW.

Others were funded by State medicaid programs or private groups. The review they performed reduced hospital lengths of stay by one-half day to 3 days.

The unnecessary use of physicians' services was brought under better control. These communitywide physician review organizations, which were able to improve upon the existing institution-based utilization review activities of the medicare and medicaid programs, served as prototypes for PSRO's.

What emerged in the form of Public Law 92-603, the PSRO statute, was a bold move forward toward addressing some of the broad concerns which had arisen with respect to titles V, XVIII, and XIX of the Social Security Act.

The PSRO program was given a very broad and necessary mandate.

As defined in the statute, PSRO's are voluntary local organizations composed of practicing physicians in an area. The statute requires the designation of PSRO areas.

PSRO areas were designated according to departmentally developed criteria reflecting legislative intent and designed to best facilitate the implementation of the program.

The statute requires that each PSRO have as members a substantial number, interpreted as 25 percent, of the physicians practicing in its area.

The requirement for such extensive physician involvement reflects the basic premise of the PSRO program: Effective peer review requires broad physician commitment and participation.

A key factor in the PSRO legislation is that it transfers the authority to make final determinations of medical necessity and appropriateness for payment purposes from the medicare intermediaries and the State medicaid agencies to the PSRO's.

This binding review authority gives the program great potential effectiveness. The statute requires the review of all health care services provided to medicare and medicaid beneficiaries in acute care hospitals, long-term care facilities, and other institutions.

Review of ambulatory care is optional for each PSRO. PSRO review of title V services is not binding for payment. Individual PSRO's are required by statute to develop norms of care and treatment from the patterns of practice of their geographic area and to use such norms as initial screening tools in the review system.

Norms, criteria, and standards will be used by nonphysician reviewers to screen out cases which require review by peer practitioners.

In this way objective screening review can occur and valuable physician time can be used in the review of the more difficult cases.

In concurrent review, a denial is possible only after peer review has occurred. Neither the PSRO legislation nor Department policies envision norms, criteria and standards to define the type of care which should be provided. They do not, in short, represent a cookbook for the practice of medicine.

Deviation from any norm, criteria or standard does not allow an a priori judgment to be made concerning the quality, appropriateness or necessity of care.

The use of norms, criteria and standards merely represents a way to objectify screening review and preserve the use of valuable physician time for problem cases.

PSRO's are required to delegate their review authority to committees within facilities in their area which demonstrate a willingness and ability to perform these functions.

The PSRO is then responsible for assessing and monitoring those institutional review programs. In some cases where an institution is considered qualified to perform some but not all aspects of delegated review, a PSRO will partially delegate its authority to the institution and share review functions with it, within the realm of administrative feasibility.

In the initial period of program implementation it was determined that the appropriate starting point for PSRO review activity is the inpatient hospital setting, since the largest amount of medicare and medicaid expenditures is for inpatient services.

The Department has therefore defined a basic hospital review system in the PSRO program manual which we believe is significantly improving the quality and appropriate utilization of care in those areas in which review has begun.

PSRO's are also given the option to propose alternate methods which are equally effective in assuring the quality and appropriate utilization of care.

The basic hospital review system includes three integrated components: concurrent review, medical care evaluation studies, and profile analysis.

Concurrent review involves review of the medical necessity and appropriateness of admissions and continued stays of medicare and medicaid patients in hospitals during the course of their hospitalization.

Medical care evaluation studies are short-term retrospective studies of the results of care and of the medical and management practices within the institutions which are performed so that unacceptable patterns can be identified and corrected.

Profiles of hospitals, physicians, and patients display trends over time which are analyzed by the PSRO to identify needed changes.

Mr. VANIK. Can the use of these profiles eventually lead to standards that may or may not help define what constitutes malpractice?

Dr. HELLMAN. I think that is a very difficult question to answer, but in the past, in review systems, the use of such profiles has not contributed to increased malpractice.

I think your question would need a much more thorough review by our General Counsel than I can give superficially now.

Again, I would like to emphasize if, indeed, it did increase malpractice, it would furnish a better basis for a judgment, and I think a protection for physicians in that they abided by certain standards which were agreed to by their local practitioners.

Mr. VANIK. Can the use of these profiles help move parts of the Nation which have consistently had different types of utilization toward a more efficient utilization?

On the east coast, the average hospital stay is two days longer than on the west coast. This costs an extra \$5 million.

Is it possible these profiles can help develop more consistency and perhaps economy?

Is there any reason why the stays should be higher on the east coast?

Is there some basic situation that requires that?

Dr. HELLMAN. There are local conditions that contribute to hospital stays. I think the PSRO review process in the beginning will contribute toward more uniform hospital stays and shorten hospital stays.

However, that is not the primary objective of the program. The prime objective of the program is to increase the quality of medical care.

Mr. VANIK. As I ask these questions, I realize that you may want to submit detailed responses to them, so when you examine the transcript you may go over them and perhaps elaborate on the responses you have made.

Dr. HELLMAN. I think we would like to elaborate on the malpractice issues.

[The following was subsequently submitted:]

The relationship between PSRO and medical malpractice is complex, as both have highly technical facets. In addition, since PSRO is perhaps the most controversial Federal program affecting the medical profession, and since medical malpractice is the most severe current problem affecting that profession, any statements made concerning their relationship are likely also to be controversial.

One issue that has arisen repeatedly with regard to PSRO and malpractice is whether the review norms, criteria, and standards developed by local PSROs will increase the incidence of malpractice litigation. While we recognize that there are opposing views, on the basis of our analysis we do not believe that the development and existence of review standards will increase malpractice litigation. Our view is based on five basic points.

First, PSRO norms, criteria, and standards are not legal standards of medical care. As defined in the *PSRO Program Manual*, norms are numerical or statistical measures of usual observed performance; criteria are predetermined elements against which aspects of the quality of a medical service may be compared; and standards are professionally developed expressions of the acceptable variation from a norm or criterion. It should be emphasized that standards, while representing "acceptable variation from a norm or criterion," do so not to *define* what good or bad medical practice is, but to *screen* those cases which are to be subject to more extensive peer review. That is, PSRO standards are not standards of medical practice; they are standards by which PSRO reviewers screen medical care. Any standard which would attempt to define medical care would be unworkable in PSRO review, since a definitional standard would be too specific for the general review of cases by trained non-physicians. In addition, a definitional standard, predetermined, could not take into account sufficiently individual variation and physician judgment and would instead lead to "cookbook medicine." Courts, we believe, would understand the difference between standards intended for screening and review on the one hand, and legal standards of medical care on the other.

Second, in conjunction with the first point, PSRO standards are necessarily general. Courts have historically refused to admit into evidence standards which are only general, preferring to apply specific standards to specific individual cases. We believe courts would recognize this distinction between PSRO standards and the legal standards of medical care also.

Third, even if introduceable into evidence, PSRO standards would become only one piece of evidence of the applicable standard of care, to be amplified or rebutted by other competent evidence.

Fourth, the basis for PSRO review standards is very similar to the basis for the legal standard of care which presently prevails. That is, the legal standard of care is that level of medical care practiced by the average practitioner in similar situations. Similarly, the PSRO review standards are developed by local practitioners relying on medical literature, their own experience, and local situations. It is therefore unlikely that PSRO review standards should represent a great departure from already existing legal standards.

Finally, the PSRO enabling legislation addresses the relationship of the review standards in granting immunity from civil liability to practitioners who follow the standards and who exercise due care. In addition, the legislative history emphasizes that while limited immunity is granted if the PSRO standards are followed, no presumption of liability should attach to the failure to follow the standards.

Therefore, on the basis of our analysis, we believe that the development and existence of PSRO norms, standards, and criteria will not increase the incidence of malpractice litigation. The standards are review standards and do not define medical care. They are general and are not specific to individual cases, and probably will not be admissible as evidence of the standard of care. Even if admissible, they would be only one piece of evidence as to that standard, and would in any event not likely differ significantly from the direction that standard might take. Finally, the PSRO legislation speaks directly to the position of the standards in litigation, providing limited immunity.

Mr. VANIK. Thank you.

You may continue with your statement.

Dr. HELLMAN. For example, significant differences in rates of hospital admission and in rates of certain surgical procedures may be identified.

Analyses of these differences may have an impact on the quality of care and utilization of services.

A PSRO management information system has been designed and implemented to provide PSRO's with the capacity to collect and process the data needed to support such a review system. It also enables HEW to collect data for the evaluation of PSRO's and their nationwide impact on the medicare and medicaid programs.

The components of the PSRO system are thus fairly simple. Physicians set and apply standards of care, assess performance, identify deficiencies, and arrange corrective action through existing continuing medical education or other means.

Quality is primarily assessed through retrospective medical care studies; appropriate utilization is monitored through concurrent review and profile analysis.

This system should significantly improve the quality of medical care and contribute to appropriate utilization of services.

In the 203 PSRO areas across the Nation there are currently 65 conditional PSRO's performing review. Fifty-five additional organizations are in the planning stage.

Mr. VANIK. I am concerned there are so few after 3½ years.

Dr. HELLMAN. I would prefer to look at it another way. I think we have proceeded with deliberate speed. There have been some questions of funding but most of these questions have been straightened out.

I think we are introducing into the practice of American medicine something which has not existed before, but it is long overdue.

It is a complex system. It requires the agreement of the physicians to succeed, and I think to have proceeded more rapidly than we have, perhaps would have been unwise and we might have made some serious mistakes.

By the end of June, these conditional PSRO's are projected to have implemented review in 1,290 hospitals, which comprise 83 percent of the hospitals in the 65 PSRO areas involved.

Mr. VANIK. I might say less than one-third of the Nation.

Dr. HELLMAN. But, again, we are developing a system that often starts slowly but which I think will make much more rapid progress from now on.

It is further projected that approximately 1¼ million admissions will be reviewed in these hospitals by the end of June 1976.

Projections for fiscal year 1977 include the designation of the remaining 55 planning organizations as conditional PSRO's.

In addition, the Department expects to fund 83 new planning organizations to cover every PSRO area in the country based on our fiscal year 1977 budget request. By the end of fiscal year 1977, 120 conditional PSRO's will be performing reviews of about three million hospital admissions.

Last December Public Law 94-182 was passed, which contains new amendments to the Social Security Act. One amendment will allow PSRO hospital review to be financed through trust funds.

After hospital review is implemented, PSRO's will expand into review of long-term care facilities and, if requested and approved, into ambulatory services review.

The PSRO system will also have the capacity to provide review of services to the privately paid health sector.

In discussing these aspects of program implementation, it also may be instructive to focus on the major problem areas which have been encountered in the years since this legislation was passed.

These are (1) acceptance of the program by physicians and payors, (2) administrative implementation, and (3) relative newness of the field of quality assurance.

When the PSRO legislation was passed in 1972 the negative reaction on the part of the Nation's physicians were almost overwhelming. The program was seen by some as an inappropriate Federal intervention into the private practice of medicine.

Due to misinformation, many physicians feared that they would be under the constant supervision of Federal bureaucrats attempting to practice "cookbook medicine."

Since the PSRO program is predicated on the concept of peer review, continued physician opposition could have crippled the program.

Fortunately, however, many members of the medical profession began to recognize the obligation on the part of the Federal Government to assure the appropriateness and quality of services paid for through its expenditures.

Some may also have viewed PSRO's as one of the legislation's authors did: The last and most significant opportunity for physicians to demonstrate that they were the most effective people to review the work of other physicians.

I think this is a very important point, sir, in that we sense an increasing acceptance on the part of physicians of this sort of review program.

In any case, the physician acceptance of the program began to increase and steady gains in participation have been occurring over the years, even beyond our resources to fund interested organizations.

Over 106,480 physicians are now members of organized PSRO's representing nearly one-half of the eligible physicians in those PSRO areas. Among conditional PSRO's the average physician membership is 52 percent.

Prior to the recent amendment, the PSRO statute authorized the Secretary of HEW to designate nonphysician organizations as PSRO's in areas where no qualified physician organization had come forth by January 1, 1976.

However, this "physician preference" period was extended by amendment to January 1, 1978, indicating the extent of congressional and departmental dedication to the idea of peer review.

We foresee no obstacle to successfully designating, by January 1, 1978, planning physician organization in almost all of those 83 areas which currently have no PSRO's

Another aspect of this reluctance to accept the program has been demonstrated by some States. Several States where existing review systems are operating have been reluctant to switch over to [the] relatively new Federal approach.

Others simply do not want to relinquish payment decisions to a self-regulating group of physicians, especially in light of the high medical costs faced by many such States.

This lack of acceptance has resulted in considerable delay in the initiation of PSRO activities in some areas.

Percent departmental decisions which have reaffirmed our commitment to local peer review hopefully will encourage more State cooperation.

The second major problem area relates to the administrative problems of initiating a very highly complex and innovative program on a national scale.

As I mentioned earlier, the PSRO mandate is a broad one. The statute provides for the review by PSRO's of all health care delivered on an institutional basis to the beneficiaries of three separate programs, administered by three Federal agencies and over 50 separate State agencies, all with legitimate program interests.

The Federal-State partnerships which exist for titles V, and XIX do not exist in the fully Federal medicare program.

Reimbursement policies, memoranda of understanding, questions of authority, all have to be worked out separately by each PSRO for the two kinds of programs.

And, as pointed out earlier, State opposition to a PSRO can delay implementation markedly.

One of the objectives of the PSRO statute was to bring the medicare and medicaid programs more into conformity with respect to their quality assurance mechanisms.

PSRO's performing review have been successful in this by setting up uniform PSRO review procedures for both programs, and they have replaced existing differing utilization review requirements.

Mr. VANIK. I would like to stop at that point and ask you to prepare an answer to the following questions. (1) which States are giving you trouble? (2) can you provide us with a list of the number of States which are still insisting on their own medicaid reviews? (3) do you have any information on the extra administrative costs this double review mechanism creates?

You might think about those answers.

Dr. HELLMAN. We will think about them, but Mike Goran can answer your questions now.

Mr. VANIK. You might get those responses for the record. I have to leave for a brief time.

Mr. VANDER VEEN. At this point, we have a series of votes here this morning but since that last vote was on a bill which is now going to be considered, we may have more interrupted time.

The chairman will be back as soon as he has a chance to vote.

You were in the process of explaining in which States it is that you are having difficulty in establishing PSRO's. Would you please continue?

Dr. HELLMAN. Yes.

The chairman had given us three questions and we are prepared to answer them now.

Dr. GORAN. Mr. Vander Veen, if I might, I'd like to restate the questions and try to answer them.

I think the chairman was interested in which States we are still experiencing difficulty with implementing PSRO review and which States are insisting on maintaining their own medical review.

These are primarily States that operate large medicaid programs, most notably California and New York, both of which have their own medicaid review systems and have considerable medicaid expenditures.

There are several other States where we are having some difficulties, but on a lesser nature. They include Michigan, Missouri, Wisconsin, and West Virginia.

I am happy to report, however, in all of these States we appear to be on our way toward reaching satisfactory resolution that will simultaneously have PSRO's implement medicaid programs and have the States stop their duplicate review activities and assume a monitoring role, monitoring the effectiveness of the PSRO review system.

We have not quite yet reached agreement, but we are close to it both in California and New York. Once that is achieved, I think we will have little difficulty in extending this to other States.

The final question the chairman asked concerned the State issue having to do with what extra administrative costs might be incurred when States are operating their own review systems where PSRO's are also performing review.

We regret we have been unable to obtain precise figures from States. SRS, which administers the medicaid program, is unable to identify from the State reports exactly how much money is involved in duplicate review systems, but there is no question that in the larger States there are some duplicative administrative costs involved. With the resolution that we are about to achieve, these administrative costs would no longer be incurred, and, as I indicated before, the States would revert to a lesser monitoring role.

Mr. VANDER VEEN. Just to carry out that question, to focus on the State of Michigan, are you about to tell me or can anyone at the witness table tell me in detail what the objection has been in the State of Michigan and with whom are you dealing, and in what ways are there duplicative costs.

Dr. GORAN. Yes, I think I can answer those questions.

In Michigan, as in many of the other larger States where we have multiple PSRO areas, the State is put in a rather difficult situation where it is simultaneously required to operate medicaid programs where there are no PSRO's and work with PSRO's which are to assume review responsibilities when they become conditional.

In Michigan we have two conditional PSRO's and eight other areas that don't have conditional PSRO's at the moment.

Thus, the State must work a double system until the remaining eight areas obtain additional PSRO's.

Mr. VANDER VEEN. You indicate that the State is divided into 10 areas for this purpose; is that correct?

Dr. GORAN. That is correct.

Mr. VANDER VEEN. Focusing on western Michigan and Grand Rapids, and Kent County particularly, what area is covered by the PSRO that would pertain to that area?

Dr. GORAN. We have currently—and I am not sure I am giving you the precise answers—two PSRO's in the Flint area and one in the Upper Peninsula area.

We have one planning PSRO and I don't have in front of me where that is. The remaining seven areas do not have any PSRO's at the moment.

Mr. VANDER VEEN. Is there any one here who can tell me about Kent County or western Michigan?

Dr. GORAN. We will have to supply that for the record.

[The information follows:]

#### PSRO STATUS IN MICHIGAN

The situation in Michigan with regard to delays experienced in implementing review is similar to that occurring in several other large States where there has been some resistance on the part of the Medicaid State agency to signing an acceptable memorandum of understanding (MOU) with the PSROs in the State. In Michigan there are two conditional PSROs located in PSRO areas I and V (geographically located in the Upper Peninsula and around Flint) and one planning organization in Area VII (Wayne county). The two conditional PSRO's have been unable to sign MOUs with the State Medicaid agency because it had in the past sought to retain override authority over PSRO final review determinations of medical necessity, counter to the requirements of the PSRO statute. However, recently progress has been made toward reaching an agreement with the State agency in Michigan and it is now in the process of considering a model MOU which would give the conditional PSROs final review authority for Title XIX services. At present, the two conditional PSROs in Michigan are performing review of Medicaid services despite the absence of an MOU. There has been no PSRO activity in Kent County to date.

Mr. VANDER VEEN. The reason I am asking about this particular area is that I can relate to it. I would like to know who you are talking to and what the objections are.

Dr. GORAN. There are not necessarily objections on the part of the Kent County Medical Association.

Due to shortages of funds in the past we have not solicited any additional planning PSRO activity from these areas.

We do plan to do so beginning fiscal year 1977 if we obtain the President's budget request. At that point we don't expect any difficulty in obtaining the support of the physicians in Michigan in establishing additional PSRO's throughout the State.

The difficulty goes to the authority of the PSRO in general and not in a particular area of the State. Other PSRO's, when making decisions regarding medical necessities, are making decisions which are binding on the medicaid program, which cannot overturn them.

That has been the issue that has provoked some consternation on the part of the medical profession in Michigan, but I think we are on our way to resolving these problems.

Mr. VANDER VEEN. Thank you.

You may continue.

Dr. HELLMAN. The Department has been criticized for its delay in producing regulations for the PSRO program. Factors which have contributed to these administrative delays include the complex interrelationships I have described, and the necessity for legal and policy decisions to be made in areas with few, if any, precedents to provide guidance.

Additionally, the passage of legislative amendments has required revisions in regulatory language. On an interim basis, while regulations are being developed, the Bureau of Quality Assurance has established two mechanisms by which policies are transmitted to the field.

The PSRO program manual, gives policy guidelines and instructions on the basic requirements necessary to qualify as a planning or conditional PSRO and how to begin hospital review.

The PSRO transmittal system, which consists of a continuing series of numbered transmittals, attempts to provide ongoing policy guidelines and instructions to PSRO's on major issues of importance to the program.

Both the PSRO manual and transmittals are issued in draft form for comment to the PSRO's and among the affected agencies in HEW. Therefore, although formal regulations are delayed on some issues, mechanisms are utilized which provide for local PSRO and other non-BQA input into policy decisions.

Mr. VANDER VEEN. If I may interrupt you there, since the start of the program, how many numbered transmittals have been sent out?

Dr. GORAN. I believe the number of now 36. These transmittals, of course, supplement the basic program manual.

Mr. VANDER VEEN. It is my understanding that there has been a complaint on the part of PSRO's about what has been characterized as a constant stream of directives that keep shifting the focus of the program.

Would you please comment on that.

Dr. HELLMAN. I think that such directives have clarified the focus of the program but I do not believe they shift the focus.

I think these letters of transmittal have been a very important element in the coordination of the medicare program in HEW and have provided interim guidance until the regulations are published.

We would be glad to submit for the record a list of the transmittals with the dates of issuance.

Mr. VANDER VEEN. Dr. Hellman, in your written testimony at the bottom of the first page and the top of the second page, you referred to the basic purpose of professional standards review organization program.

You stated that it was first to improve the quality and, second, to make sure more cost effective, the over \$25 million in Federal expenditures for health care services.

I am looking at a document which summarizes the purposes of PSRO's as being, first, to assure that programs are medically necessary; second, that the programs are provided in accordance with professional standards; and, three, in the case of institutional services, rendered in the appropriate setting.

I see you shaking your head; therefore, I take that to mean that you disagree with that statement.

Dr. HELLMAN. I don't think there is an incompatibility. It seems to me—and I was a practicing physician for over 30 years, and subject to all kinds of review—that the improvement of quality of medical care goes hand in hand with the efficiency of medical care.

As you improve quality, you must, of necessity, improve the efficiency of the method of giving care.

Mr. VANDER VEEN. I would not care to dispute that. I have no intention whatever of disputing your medical judgment, but I do question whether your statement of the basic purpose of the program which you state to be to improve the quality of the delivery of health care

services is the same as the stated purpose of the program in Public Law 92-603.

Dr. HELLMAN. I still think, sir, these are compatible.

Mr. VANDER VEEN. They may be compatible, but are they the same?

Dr. HELLMAN. I did not mean to interpret the law for you, sir. They are not entirely the same, but they are compatible and one influences the other.

Mr. VANDER VEEN. This could well be that they may be compatible and they could influence the other, but my question to you, Doctor, is whether or not the statements that have come to the attention of the committee, such as—and I am quoting here—

We have been confronted with changes in these guidelines and directives made after having spent many hours preparing required materials according to guidelines in the PSRO program manual and letters of transmittal available to us.

We have been confronted with changes in these guidelines and directives made after submission of some of these materials requiring duplication of effort.

This is from a California area PSRO. I am wondering if that kind of complaint to this committee might not derive from a series of transmittals which might not be really stating or in keeping with the stated purpose of PSRO's as outlined in the basic legislation.

Dr. HELLMAN. Let me ask Dr. Goran to answer that.

He has been responsible for many of these letters of transmittal. I don't think they have, but I would like to have Mike try to answer you.

Dr. GORAN. I think, at least in my mind, a more likely explanation for this complaint has to do with the new, evolutionary nature of the program.

Most of the early PSRO's were, in fact, subject to a program in which basic policies were being formulated as the program was being implemented.

That still continues to a certain extent today, for instance, as we move from hospital care review to long term care review.

It is true that some PSRO's which were early into the review business have been asked to make modifications in their program through these transmittals, but these modifications are almost always intended to improve the program performance and to make it more effective in the context of medicare/medicaid and title V programs.

Mr. VANDER VEEN. Have any of the transmittals been directed to the question of whether or not the programs are medically necessary?

Dr. GORAN. The issue of medical necessity is the subject of the program manual and many of the transmittals address methods by which the PSRO's should determine medical necessity and inform payers whether or not to pay for services.

Yes; they have been a subject in the transmittals.

Mr. VANDER VEEN. Have they been directed to the question of whether or not the medical services are provided in accordance with medical professional standards.

Dr. GORAN. Yes.

Mr. VANDER VEEN. And also whether the services are being rendered in the proper setting.

Dr. GORAN. Yes; these provision concern much of the guidance in the transmittals.

MR. VANDER VEEN. Frankly, I still have a problem with the statement that the fundamental purpose of the PSRO program is to improve the quality of medical health care delivery.

DR. GORAN. If I might, for a second, just try to explain what from my perspective the issues are focusing on. Professional standards established by the local PSRO will, in our mind, improve care and I think those are the two statutory references which we are saying are not only compatible but quite integral to quality assurance.

MR. VANDER VEEN. I think if we can agree that the determination of these three points laid out in the legislation will result in improvement of the quality of health care delivery, then I think we will be on the right track.

DR. GORAN. That is certainly what we agree.

DR. HELLMAN. That is what I meant to imply in the statement. I am sorry that it did not come across that way because I think that is the policy of the Department.

MR. VANDER VEEN. I think you understand that the purpose of our inquiry is to ascertain to the extent that we can the agencies concerned are carrying out the legislation in the way that we intended to be implemented.

DR. HELLMAN. I can assure you that the Department, I, Dr. Goran, all of us, have exactly the same intent.

MR. VANDER VEEN. Fine.

Excuse me for the interruption.

DR. HELLMAN. I think it is a very important issue, sir.

Financial support to fund PSRO's has been a recurrent problem. Appropriations have not always been as high as requested by the administration.

We have not had enough funds to support all organizations interested in planning for PSRO designation and we have not had enough funds to allow all of those designated as conditional PSRO's to initiate review in hospitals as fast as they could.

The recently-passed Social Security Act financing amendment, as previously mentioned, makes certain changes in PSRO reimbursement systems which assure that ongoing financing of hospital review will likely result in more rapid assumption of review responsibility for all direct hospital review authorities.

The amendment calls for:

First. Reimbursement for all reasonable costs of nondelegated hospital review, as determined under regulations of the Secretary, to be paid for out of medicare benefit trust funds rather than direct appropriations.

Second. Hospitals to be reimbursed for 100 percent of the reasonable costs of delegated review without any requirement for apportionment of such costs among non-Federal patients. The fiscal year 1977 budget request of \$62 million reflects a transition to these new financing procedures. This would fund 120 conditional and 83 new planning PSRO's.

The third problem is simply one of the undeveloped state-of-the-art of quality assurance review of medical care. Quality control in the medical field has not until recent years focused on the actual care-giving process or the outcome of care.

Therefore, models are limited for PSRO guidance. However, the PSRO program has incorporated the best and most promising review methods that have been developed to date and it has the necessary flexibility to adopt new and better mechanisms as further research reveals them.

We are now in the process of developing policies and procedures for the orderly implementation of statutorily required long-term care review in the Nation's long-term care facilities.

Mr. VANIK. At this point, what research are you conducting or sponsoring?

Could you give us a list of experiments for the record?

I am talking about the new mechanisms.

Dr. HELLMAN. Let me give you one verbally and then submit a list for the record, if I can.

We have just begun, through our Federal hospital system, an experiment to test whether concurrent review such as that instituted by PSRO's is an adequate or superior substitute for the traditional retrospective review.

This is a very carefully planned experiment and should give us some very interesting answers.

Let me submit the rest of the experiments for the record.

Mr. VANIK. Without objection, it is so ordered.

[Information requested follows:]

#### INFORMATION REQUESTED ON LONG-TERM CARE REVIEW EXPERIMENTS

The Bureau of Quality Assurance is currently moving into the area of PSRO long term care review in two ways:

(1) We are sponsoring a demonstration project which will fund ten currently conditional PSROs to undertake various approaches to the review of long term care services for demonstration and assessment purposes. This experiment will last for two years. The results of these demonstrations will be studied by BQA in the development of further long term care review guidelines and regulations. The ten PSROs which will participate in this experiment will be selected by July 20, 1976 from the applications received.

(2) Eight other conditional PSROs are currently performing some long term care review. However, these are not demonstration projects. These PSROs have instead assumed responsibility for review which had been performed by them, or other review organizations, prior to their designation as PSROs. For instance, several of these PSROs were previously private foundations for medical care performing PSRO type review in many areas. Rather than allowing the suspension of already implemented long term care review to occur due to the transition to PSRO status, BQA has moved ahead to fund these organizations to continue their review activities.

Dr. HELLMAN. As with any new program in a field, it has been difficult to know exactly how to evaluate the success or failure of a particular PSRO or of the program itself.

Statistics can be misleading or noninformative. Nevertheless, such information is important as a norm by which later performance by other PSRO's can be evaluated.

Perhaps an effective manner in which to evaluate the program as a whole is to look at our goals and objectives and try to measure how close we have come to them.

The primary purpose of the PSRO program is quality assurance. Has the program been effective in this role? Medical care evaluation studies and profile analysis are the best tools for analyzing the quality of care which is delivered. Although both processes are retrospective,

it has been shown that deficiencies in institutions have been corrected after recommendations were made by medical audit committees.

Mr. VANDER VEEN. May I interrupt you again at that point?

I ask your pardon for interrupting you so often, but, again, you made reference to what is the primary objective of the program.

In listing the three things I did earlier, there was one other legislative objective stated which I did not mention and that was to determine what economies can be made in the delivery of health care services and no reference in your testimony or in anything that has been said here today has been made to that point.

Would you please react to that?

Dr. HELLMAN. I am going to get into that in just a second.

Mr. VANDER VEEN. I am sorry I interrupted you.

Dr. HELLMAN. If I don't cover it adequately, I would be delighted to discuss it further.

Since readits are performed to measure the effectiveness of a corrective action, it is relatively easy to measure the success of such an action.

Few PSRO's have been conducting review for a sufficient length of time to develop profiles on an institution or individual practitioner. However, evidence would suggest that the results would be similar to that of medical care evaluation studies.

That is that when problems are identified, corrective action recommended, and a followup profile made, deficiencies in practice or knowledge can be corrected.

Concurrent review of medical necessity can also impact on the quality of care a patient receives. For instance, if it is determined by a PSRO physician reviewer that a particular operation for which a patient has been admitted to the hospital is not in his best medical interest, that patient has benefitted in a qualitative sense from the review decision because he is spared the risk of unnecessary surgery.

In these ways, PSRO's have been shown to impact favorably on the quality of care provided to Federal patients.

A secondary PSRO objective is to make Federal programs more cost effective by eliminating Federal reimbursement for unnecessary or inappropriate procedures provided to titles V, XVIII, and XIX beneficiaries. There are some indications that concurrent review has been proven effective in this capacity by reducing average lengths of stays.

If I could amplify on that point a minute, this is very preliminary data and it will be some time before we have final data. But this system will provide the information on the reduction in lengths of stay.

I think we should not be unduly optimistic for the long run, but it is quite possible that in the short run, we will get a very precipitous drop in stay.

However, in the long run, it is possible that review of the kind we are talking about will put sicker patients into hospitals, those more deserving of hospital stay, and it is possible that this would result in a plateauing of hospital lengths of stay, or even a rise in hospital lengths of stay in some areas.

Mr. VANDER VEEN. I appreciate that comment and I am also pleased that this is recognized as being one of the principal aims of the program.

The pressure that Members of Congress are beginning to receive to an ever-increasing degree for a national health plan is traced directly to the spiralling costs of health care delivery.

It is getting beyond the capacity of not just the people who are not well-to-do but of a vast percentage of our population so this is a part of the program in which Members of Congress will have a great deal of interest.

Dr. HELLMAN. I just wanted to be sure that we were clear that this program alone is not a cost-containment program.

Mr. VANDER VEEN. I believe it is not intended to be cost-containing. It is intended to find ways in which to reduce costs.

Dr. HELLMAN. I think in many ways it will achieve that.

Mr. VANDER VEEN. I trust so. Thank you.

Dr. HELLMAN. This subject is covered in my next paragraph.

A word of caution on expectations of a PSRO's ability to control expenditures. A PSRO is primarily a mechanism for assessing the quality and appropriateness of medical care services which are delivered. Other elements, such as financing systems, program coverage decisions and rate-setting mechanisms primarily address cost controls.

The quality assurance activities of PSRO's may increase the utilization of some services while decreasing that of others.

An effective PSRO program can, however, assure that whatever Federal dollars are spent on health care will only be spent on appropriate quality care.

Another role of the PSRO program has been as a model for national health insurance planners who look to our program as the prototype of a system to monitor the delivery of health care under a national insurance system.

The problems that have surfaced in PSRO and how they have been solved are important lessons for national health insurance planners.

What, then, is the verdict on the progress and future of the PSRO program?

I think it is fair to say that we have made good progress in several areas. By the end of 1978 all medicare and medicaid hospital admissions will be under PSRO review.

PSRO's which are currently conducting hospital review will extend review to long-term care facilities. Again, by 1978 PSRO's may also have expanded review to private insurance companies, an activity which we are encouraging once Federal review is in place.

The indication, where we have reliable data, is that PSRO review is having a beneficial impact on the quality of care in hospitals. Overall PSRO's will also probably have a favorable effect on spiralling health care costs in the public, and to some degree, the private sector.

There is still a great deal of work to be done in the PSRO program before it can be said to be fully implemented. But when that point is reached, I think we will find that PSRO's, along with other new Federal health initiatives, will have had and continue to have a profound and beneficial effect on health care delivery.

Mr. Chairman, this concludes my prepared remarks. My colleagues and I will be pleased to answer any questions you or other members of the subcommittee may have.

Mr. VANIK. Dr. Hellman, on the status of implementation, it was Congress' intention that conditional PSRO's change to operational status after 2 years. We understand the 14 original PSRO's, after 2

years, are not ready to change to operational status. My question is: Why are they not ready and what is planned at this point?

Dr. GORAN. It is true that the original conditional PSRO's are approaching 24 months of conditional status. We do plan to redesignate them all once again as conditional organizations.

In large measure this is due to delays, our delays in implementing the program, rather than any defects these PSRO's have.

One of the responsibilities of a PSRO is to review services in all institutional settings.

We have not yet been able to initiate long-term care review in institutions and have decided, as Dr. Hellman indicated, to move into that area rather rapidly over the course of the next several years.

Most of the PSRO's have had experience in the hospital setting. We hope to work with them to gain experience in long-term care settings by redesignating them as conditional organizations.

After they gain satisfactory experience in hospital and other long-term care institutions, they will move from conditional to operational status.

Mr. VANIK. On the question of regulations it has been 3½ years since we enacted this program, and we are still operating without final regulations.

Could I ask why final regulations have not been issued?

Dr. HELLMAN. While you were out of the room, we had a fairly long discussion on this point, but let me answer you briefly.

The issues are very complex. First, many regulations require not only secretarial decision, but they require legal decision also.

Two, there have been changes in legislation which require rewriting of these regulations.

We regret the delay, and we think we have been unduly long, but we have used a method of transmittal of guidelines to the various PSRO's in cooperation with the medicaid and medicare people. In a way, that has substituted for regulations. We don't think that, although we have been delayed and regret it, we have actually delayed the progress of the program.

Mr. VANIK. Do they have enough in regulations to give them parameters of action so we are not inhibiting the development of the PSRO's?

Dr. HELLMAN. I think we have enough.

Mr. VANIK. Do you have any idea when we might get the final regulations?

Dr. GORAN. We do have a schedule that, unfortunately, we are constantly updating, but we do now project that notices of proposed rulemaking in the major substantive areas affecting review in hospitals will be out by the end of the summer.

Then, after going through a comment period, we will go to final rulemaking.

Mr. VANIK. This is the second medicare program with which we are dealing, and both programs are without final regulations.

Are there any other medicare programs created by Public Law 92-603 that are without final regulations?

Mr. TIERNEY. Mr. Chairman. I don't think there are any major regulations that have not been promulgated, with the exception of the conditions of participation for renal disease providers.

I would like to make a comment on the PSRO's. I think the Department really would have been subject to tremendous criticism had it moved maybe any more precipitously than it has on these regulations.

This is a complex and very brandnew area, and we are imposing a new system on the American practice of medicine which has been going on for 200 years. It takes a lot of doing.

Regulations become very concrete. When you say something in a regulation, that is it. We are still trying to find out a great deal about these things.

I know from the medicare program itself the people on the other side are always anxious to see some kind of formalized statement, but often it is a very good idea not to have it.

Mr. VANIK. Let me ask you this so we can put this all in perspective.

I realize that perhaps increased quality and lower costs are not always compatible. Do any of you on the panel share the belief that PSRO's would and could save money and serve as a cost control method?

Is that sound or should we look elsewhere for cost control?

Dr. HELLMAN. That concept is sound to a degree. I think as we review programs where illness is paid for by the Federal Government, we are going to make a more efficient program.

We are going to shorten the hospital stay and we are going to prevent unnecessary procedures.

However, just by doing this and making the system more efficient, we may get sicker individuals taking the place of those whom we prevented or got out of the hospital earlier.

What I think you are going to get in the future is a rather precipitous drop in the length of hospital stay and in the number of unnecessary stays and procedures.

Then you are going to get a plateau, and cost containment beyond that point will take some other legislation.

Mr. VANIK. I happen to be currently involved in medical care for my own family. One of the things that the hospital is doing which provides me with a very close look at procedure is that within the next few days they will be moving my wife into a hotel nearby which will keep her nearby but close to the hospital.

It will shift the cost from the carrier to me. I think it is a wise procedure; just the idea of having a fine quality hotel right next to a great medical center makes so much sense, because it is a place to keep patients until you are ready for them. It is a place to keep patients who don't have to be in the hospital, yet have to be close to its facilities on an outpatient basis or subject to review.

I cannot see that this sort of thing, standing by itself, is a facility which can reduce medicare and health care cost. We must admit it is a very wise and provident thing to do.

Dr. HELLMAN. You may have noticed it is better for the patient.

Mr. VANIK. That is true, and that is probably the primary reason that motivates this type of care. It never occurred to me that placing a patient in a hotel that is near a hospital would make sense, but it is very wise indeed and probably ought to be made a part of our future hospital planning.

Dr. HELLMAN. I think the PSRO idea will encourage the development of other innovative hospital practices as we begin to look at current practices.

Mr. VANIK. Still, it is considered a useful tool in cost control?

Dr. HELLMAN. It contributes.

Mr. HATSLIP. I am Gene Haislip, Deputy Assistant Secretary for Legislation.

I think what has been indicated about cost savings possibly for the PSRO program is correct, but I should also point out to you that there is a great deal of daily concern and study of many other mechanisms to impact favorably on the cost picture.

I would say probably one of the two or three principal concerns in the health field is the total increase in cost in the health care system.

I don't believe we would suggest that this or the 7 percent cap that the President is proposing is going to offer an adequate answer at the time. We don't have that total adequate answer.

Mr. VANIK. I have another related question.

How will the medical records handled by a PSRO be treated?

Dr. HELLMAN. Let me ask Dr. Goran to go into the medical records issue because it is a very important one.

Dr. GORAN. The PSRO statute requires that PSRO's be responsible under rather stiff penalty to keep confidential the review records of both individual patients and practitioners.

PSRO's do maintain profiles on individuals and on practitioners of care in their area, but they are required to keep these confidential, although an individual may inspect his own review record.

Mr. VANIK. Will data collected by the PSRO's be made public which will enable the consumers to know when malpractice is occurring?

Dr. GORAN. The first part of that question—the answer is "Yes."

Aggregate data will be made public. It will come from the PSRO Federal reporting system which will not disclose information about individuals but only about aggregate performance patterns of care.

In reference to the second part of your question, that data, in my opinion, certainly won't be detailed enough to provide any real information regarding degree or extent of malpractice.

Mr. VANIK. Will data be made public which will enable consumers to select either the best hospital or the best physician in the area?

Dr. GORAN. Data made public will certainly assist consumers.

Mr. VANIK. You should clarify that. So many people are left at the peril of choice. Where they end up is sort of a roulette game.

First of all, the assignments are generally made by general practitioners, if you can find one anywhere, and he would in the normal course of events probably suggest a surgeon and that surgeon is limited to a certain facility. The entire procedure seems to be carried out without your realizing what is happening. The patient may be moving toward a facility which may not be the best place for him. It turns out to be a chain of events in which the person making the choice or exercising the freedom of choice is most often confronted with the idea of making a mistake.

I think quite frankly if there is a way to evaluate and designate those facilities that are superior, it would probably raise the level of the whole profession and the whole business in the sense that the competitive system would ferret out and quality would be discernible.

Dr. GORAN. If I may add to that—I don't want to mislead you with my previous response.

Data in the PSRO program is primarily used to help the PSRO improve quality. It certainly should assist in helping individuals make more informed choices, but I don't pretend that, and I don't think the state of the art is such that PSRO's know or or anyone else really knows today how to put together the kind of data I think you are talking about.

I think PSRO data will be helpful to the consumer, but it is primarily intended to help in the local review activity.

Mr. VANIK. With respect to financing, Congress cut the PRSO budget because they were not sure of the Department's ability to administer the program wisely.

Last year Public Law 94-182 opened up the trust fund for financing. In fiscal year 1977 how much funding do you anticipate will be generated through the medicare trust funds, how much from the general revenues and how will the mix of these funds be coordinated.

Dr. GORAN. In the President's financial 1977 budget we have protected \$62 million in the request through direct appropriations and have estimated that an additional \$27 million will flow through the new trust fund financing mechanism established by Public Law 94-182.

Mr. VANIK. That will give you almost \$90 million.

Dr. GORAN. That is correct.

Mr. VANIK. For fiscal year 1975 the House Appropriations Committee cut your budget because you could not tell them how many people were involved and who was running the program.

How many people work on PSRO matters?

Dr. GORAN. Currently there are about 173 employees in BQA and the Division of Quality Standards regional offices in the 10 HEW regions.

Mr. VANIK. How about in BHI?

Mr. TIERNEY. We have the whole medicare network who have a relationship with it.

Mr. VANIK. How many with the Bureau of Quality Assurance?

Dr. GORAN. 126 in the Bureau of Quality Assurance in the central office, and 187 in the regional offices.

Mr. VANIK. Is that all there are elsewhere?

Mr. O'ROURKE. There are about six in the Secretary's office.

Mr. VANIK. Who is the individual responsible for the program below the Secretary of HEW?

Dr. HELLMAN. Dr. Cooper, and then the Administrator of HSA, which is my job, and the man directly responsible is Dr. Goran, Chief of the Bureau of Quality Assurance.

Mr. VANIK. What has been achieved as a result of the \$120 million spent to date on the PSRO program?

What results can we talk about in the area of quality of care and the slowing down of the rapidly raising health care problem?

We spent \$120 million. Now we are going to have to tell people what we got for it.

I just want to give you some idea of our problems. In the budget process, for example, we have a mandate to cut medicare by \$450 million and none of my colleagues can tell me where we ought to do it or how.

I want you to know we are under intense pressures that we have generated for ourselves. These problems are going to be shifting to our side of the table because we are going to have to have a cost accounting for just about every dollar involved or we won't get them.

Mr. TIERNEY. That cut came from your side of the table.

Dr. HELLMAN. I think the simplest answer to your question is that we have established 120 PSRO's and with the current financing plan, all 203 will be established by 1978.

If you are asking me for an evaluation——

Mr. VANIK. What would you say in a capsule we have gotten out of this now?

I am not being a critic. I just want to be able to advise my colleagues.

Dr. HELLMAN. It is too early to give a precise evaluation but we have put into American medicine a review system——

Mr. VANIK. A new ingredient.

Dr. HELLMAN. A new one which was long overdue. No business would ever have run the way medicine was run. Business carries on inventories and marketing reviews and so on. Medicine never did.

It is a new field and I think it is premature to try to make an evaluation other than what I have given you in this testimony. But, personally, having lived with this kind of activity for a long time, I can see tremendous benefits from it.

I think premature evaluation will get us into trouble that we don't want to get into. We may make false statements or false promises.

It is like the delivery of a baby. You don't evaluate the process when the baby is half delivered. You wait until it has been delivered.

Mr. VANIK. Are the delays behind us now?

Dr. HELLMAN. I think the majority of them are behind us.

Mr. VANIK. What was the reason?

Was it physician opposition?

Dr. HELLMAN. Some of it was funding, some physician opposition, some State interests that were different from ours, but by and large I think it was due to the complexity and the newness of what we were trying to do.

Mr. VANIK. I want to say as one professional man to another that I think that in these matters and in the work that you do that in spite of the very frequent criticisms I level at the profession, I think the profession has done a lot more, really, than the law profession has in moving forward to provide new and innovative plans of service and for providing peer review and all those many things that make up for quality.

We have very little of it in my profession, and in spite of all the criticism we have about yours, I think you are far ahead of our profession.

Before review is delegated to a hospital, what checks are employed to insure that the hospital has a review system capable of fulfilling PSRO functions?

Dr. GORAN. The PSRO goes through an assessment process whereby each hospital is first asked whether or not it wishes to seek delegation of any review functions.

If it does, the PSRO must assess its capacity. After it delegates review to a hospital that it believes to be capable, the PSRO monitors hospital performance and if hospital performance is not effective, the PSRO remains responsible and must either revoke delegation or provide assistance to the hospital to improve its performance.

Mr. VANIK. We have had a lot of contact with representatives of health care practitioner groups. They are all concerned about the role they will be playing in the PSRO program.

Do you believe it will improve the program if other medical specialties are allowed in or would it impede and congest your efforts?

Dr. GORAN. That, of course, is a sensitive issue that has been with the program right from the beginning.

As you know, only physicians are able to be members of PSRO's. It has been discussed quite a bit at PSRO council meetings and it was brought up at the most recent one.

Clearly, the PSRO program must involve all the health professions and consumers. The current program does make every effort to involve nonphysician practitioners in peer review within the context of the PSRO framework and the program manual encourages widespread involvement of nonphysicians and encourages consumer participation on PSRO boards as well.

I think honestly it is too early to tell whether or not this will be as effective as is needed. I think it is encouraging to report, however, that the other health professions have worked diligently to develop review criteria, to set up review mechanisms and to work jointly with local PSRO's in the establishment of relationships.

Mr. VANIK. I want to express to you, Dr. Hellman, and the other gentlemen, the gratitude of the committee for your fine cooperation this morning.

We have a lot more questions but we will field them by communication and try to expedite development of the record.

If there is anything you want to add to the record, you might get it in within the next couple of days.

I want to express on behalf of the subcommittee our gratitude for your appearance and your response to our questions.

Dr. HELLMAN. The Department appreciates your interest, Mr. Chairman, and we were delighted to have the series of questions you submitted to us.

Mr. VANIK. I think in this dialog you can get from the Congress and its committee some idea as to our thinking. It is the sort of thinking that can be used by the other legislative committees in developing their legislative program, and I think by this interchange we can really make the system work better and more efficiently, and provide the quality standards we consider so important.

Thank you very much and congratulations on your assumption of responsibility. You can see we are on schedule.

The subcommittee is now adjourned subject to the call of the Chair.  
[Whereupon, at 11:45 a.m., the subcommittee adjourned subject to the call of the Chair.]

[The following statements were submitted for the record:]

## STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman. We appreciate the opportunity to present written testimony to your Subcommittee's oversight hearings on Professional Standards Review Organizations.

In your review of PSRO implementation, it is imperative that you consider a glaring inequity currently on the books as law; reference is to the language whereby the makeup of PSRO review boards is limited entirely to medical doctors and osteopaths.

As an organization which represents 19,000 of the nation's optometrists, the American Optometric Association rejects this current stipulation which patently excludes our profession from taking part in this important peer review process.

The profession of optometry was one of the leading proponents of the true peer review concept, and we continue to heartily support the ideals which call for peer performance review.

As the Act stands now, a profession not familiar with another professional's procedures and education will be establishing criteria for evaluation and assuming final review. Evaluation implies that the evaluator will rely on judgments based on his own professional background and experience.

Optometrists must review the care provided by optometrists. By virtue of specialized education, training and practice, they are the only health care practitioners capable of reviewing optometric patient care situations to guarantee each individual the care he needs at a reasonable cost.

The patient cannot receive the best health care an optometrist is trained to offer when the final criteria for evaluation of that care is by another professional not familiar with the full realm of optometric care and procedures.

Along these lines, it is also vitally important that the peer review program be coordinated with advisory groups. This can prevent future difficulties as the review process widens and includes out-patient services provided by health professionals.

In conclusion, we again stress the two main areas we feel should be corrected in this law:

1. It should insure that the public benefits by receiving quality health care at a reasonable cost. This would best be accomplished by a specific provision requiring each health care profession to evaluate their own specialty.

2. It should insure the continuity of minimum cost quality care by the viability and creation of independent primary care advisory groups composed of optometrists, dentists and other similar health care providers.

The American Optometric Association commends Congressmen J. J. Pickle, Tim Lee Carter and Kenneth Hechler for their recent legislative attempts to correct this restrictive law by the introduction of H.R. 13704, H.R. 13771 and H.R. 13398, respectively.

We strongly urge the House Ways and Means Committee include the intent of these bills in necessary amending legislation

## STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, BY GARY L. GARRETT, ASSOCIATE DIRECTOR, PROFESSIONAL RELATIONS DEPARTMENT

Mr. Chairman and members of the Subcommittee, the American Physical Therapy Association appreciates the opportunity to present written testimony to the Subcommittee's oversight hearing on Professional Standards Review Organizations.

In your review of the development and implementation of the PSRO program, it is imperative that you include a review of the PSRO legislation which includes the nonphysician health care practitioner from any policy making role in the PSRO program.

The American Physical Therapy Association is a national, nonprofit, professional organization composed of 53 chapters serving over 25,000 members in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. The American Physical Therapy Association supports the intent of the PSRO legislation and the principle of peer review. However, according to the present PSRO legislation, physical therapists and other nonphysician health care practitioners essentially have no voice in how they will participate in PSRO activities. Under the present legislation, all PSRO policy is determined by medical doctors and osteopaths.

Although the American Physical Therapy Association endorses the concepts inherent in peer review as mandated by the PSRO legislation, it is at the same time concerned, because physical therapists, as well as all other nonphysician health care professionals, have had little opportunity for input into the decisions made at the national, state or local levels regarding their participation in PSRO activities. At present, PSRO Planning Organizations are writing plans for nonphysician review activities and Conditional PSRO's are implementing plans already written. The Association has little evidence from its membership that they have had the opportunity to participate in the development of these plans. Also, Statewide Professional Standards Review Councils and their advisory groups or PSRO advisory groups in states without statewide councils have not yet been appointed and physical therapists therefore have had little input in the decisions made at any level in the PSRO program.

Since physical therapists and other nonphysician health practitioner groups have been legislated the right to conduct their own peer review after medical necessity and the appropriate level of care have been determined by a medical doctor or osteopath but only given an advisory role in the PSRO organizational structure and because the present opportunities for such an advisory function is spotty or nonexistent, the American Physical Therapy Association believes that it is imperative for the present PSRO legislation to be amended to clarify the role of physical therapists and other nonphysician health care practitioner groups in the PSRO program.

The Association believes that patients cannot receive the best care physical therapists have to offer unless physical therapists have the opportunity to set the evaluation criteria for the care they deliver to patients and play a part in the development of the mechanisms by which they will be evaluated.

In conclusion, the Association believes it is imperative for any changes in the present legislation to include: (1) Full participation in PSRO policy development by physical therapists and other nonphysician practitioners; (2) Clear delineation of the role of the nonphysician health care practitioner; (3) Provisions for nonphysician health care practitioner representatives to be named to the National Professional Standards Review Council, Statewide PSRO Councils and to the Board of Directors of each designated PSRO; (4) Nonphysician health care practitioner participation in the development of plans for nonphysician health care evaluations in Planning and Conditional PSRO.

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THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.,  
Rockville, Md., June 30, 1976.

Hon. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S.  
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: On behalf of the 400,000 health care professionals who are joining in this statement, I would like to express appreciation to the Oversight Subcommittee for its decision to hold hearings on the Professional Standards Review Organization (PSRO) program. We cannot overemphasize the program's potential for improving the quality of health care which Americans receive and for ultimately contributing to the stabilization of health care costs. The Subcommittee's action at this time illustrates the persistent congressional monitoring which a program of this significance deserves.

One philosophical foundation for the PSRO program is adherence to the concept of peer review. Peer review affirms the conviction that the quality of an individual's activities can best be assessed by other individuals with similar training and experience. As applied to the health field peer review asserts that each health profession is best able to evaluate the quality of the health care which it provides. The Report of the Senate Committee on Finance (S. Rept. 92-1230) accompanying the PSRO amendments of 1972 supported this assertion by recognizing the appropriateness of organizations of professionals undertaking the review of members of their professions.

As the PSRO law and subsequent regulatory materials indicate, health care in the United States involves considerably more services than those which physicians provide. Nursing, pharmaceutical, nutritional, rehabilitative and other services all play important roles in the coordinated team approach which every patient requires. The physician must rely upon the professional judgment of other

health professionals with training and experience in areas which are not generally emphasized in the physician's training and which are not regularly a direct part of the physician's daily practice. Many different health care practitioners provide individual patients with the services needed to restore and maintain health. These same practitioners must also be given ample opportunity to assess the quality of services which their peers provide.

In light of the integral role played by non-physicians in the health care system, we believe that there is a clear need to strengthen non-physician participation in the PSRO program. First of all, true peer review requires that, just as physicians should assess the services provided by physicians, so too other health care practitioners must review the services provided by their respective peers. The training and practice of each health care practitioner is to some degree unique in content. The basic and graduate level educational requirements for each profession are distinct in character and individually designed to meet the specialized needs of each profession's practice. The uniqueness of each profession mandates the need for providers of a service to assess the quality of that service as delivered by their peers. Truly *quality* review cannot afford to overlook this fact.

Secondly, the cost effectiveness of health care services will be improved if the recognized capabilities of all practitioners are used in the review process. Money, time and *quality of patient care* can be preserved, only if the review process incorporates the expertise of the right persons at the right time. Physicians alone should not assess professional service with which they are only tangentially involved. This responsibility belongs with the members of the professions which provide those services. It would be ironic if an inappropriate review process under the PSRO program diminished the quality of patient care and failed to eliminate unnecessary federal expenditures for health care. It would be incredibly wasteful and irresponsible if, at a time when inflationary health care costs are cited as reason for limiting patient benefits PSRO dollars should result in less efficient return due to the failure to involve the right person at the right time in the review process.

Providing for the health care of American citizens encompasses a multi-disciplined effort which is not likely to change in the years ahead. If the review standards for the PSRO program recognize this existing multiplicity now, the need for later revisions and amendment will be avoided, with the resulting benefit to both the health and pocketbook of the patient. For these reasons we believe that the involvement of all health care practitioners in the PSRO program must be strengthened and increased. We, therefore, recommend the following:

1. Adequate representation of all health care practitioners be required in the membership for all Professional Standards Review Organizations;
2. The National Professional Standards Review Council be reconstituted to include representation of all health care practitioners; and
3. The Statewide Professional Standards Review Councils be reconstituted to include the mandatory representation of all health care practitioners.

As a necessary first step we recommend that non-physician health care practitioners be provided with a formal mechanism for input at the national level. A National Advisory Committee to the National Council must be established. This advisory committee should represent all the non-physician health care professions whose services are covered under Medicare and Medicaid. It should be specifically charged to assist these professions in the development of standards of service. Lines of communication with the National Council should be outlined in detail, along with areas of responsibility for issues related to non-physician practice.

The Department of Health, Education and Welfare has been supportive of efforts to increase the role of non-physician health care practitioners in the development of national policy relating to their services. The National Professional Standards Review Council, however, has only authorized an informal liaison network. This arrangement is not conducive to effective communication between the Council and the health professions which comprise the network. A formal advisory committee, therefore, is necessary to ensure the cost effective review of the quality of health services which the Congress desires and to which the public is entitled.

On behalf of all who have joined in this statement<sup>1</sup> I extend our appreciation to the members of the Subcommittee for the opportunity to present this testimony. If either collectively or individually, we can be of assistance to the Subcommittee in its review of the PSRO program, please do not hesitate to call upon us.

Sincerely,

JAMES J. GARIBALDI,  
*Executive Director.*

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#### STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

In behalf of the more than 41,000 members of the American Psychological Association, we appreciate having the opportunity to share with the House Ways and Means Committee on Oversight information on situations that has come to our attention as psychologist health providers have come in contact with the PSRO program and its local review panels.

Nationwide, there are approximately 23,000 psychologists licensed or certified for independent practice. Forty-nine states and the District of Columbia have laws regulating the practice of psychology. The newly developed National Register for Health Service Providers in Psychology, now in its second printing, identifies nearly 8,000 licensed or certified psychologists as health providers.

Already a well recognized health profession, psychology is playing a continually expanding role in health care planning and delivery. Psychological services, provided independently of physician referral, are directly reimbursable under the Federal Employees Health Benefits Plan (FEHBA) and the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS). Nearly ten million people are covered by these two plans alone. Several studies (among them the Cummings-Follette Study, the Kennecott Copper Study, and the BLK Group Study involving Medicare) have shown that comprehensive and well-planned psychological service delivery could result in a dramatic decrease in the overall medical utilization rates for each patient population measured.

Along with a growing involvement in Medicare service delivery, psychology has been playing a significant role in the Medicaid program. Sixteen states currently provide for reimbursement of direct (without physician referral) psychological services through their state Medicaid plans. While psychology's impact in Medicare and Medicaid casework is most clearly felt in the outpatient services area which is currently outside of the short-stay general hospital environment currently receiving the attention of PSRO review, it is certain that the PSRO program will in the foreseeable future impact upon our profession to a much greater extent than it does now. Our membership is concerned, therefore, about the ground rules currently being developed which will govern the conduct of PSRO peer review. It is our hope that these rules will take into account the intent of the Congress which was made clear when the legislation creating PSRO was enacted, which clearly called for practitioner review performed by practitioner peers. We are concerned that not enough attention is being given to the question of non-physician health provider participation in the PSRO program. Decisions that are now being made without adequate non-physician involvement or consultation will seriously affect the manner in which these professions relate to PSRO activities and, eventually, to health planning.

Psychologist health providers have run into a wide variety of problems dealing with PSRO, and the experiences vary widely from region to region. In Massachusetts, for example, psychologists have been told by PSRO officials that review activities in that state will focus exclusively on physical care, and that mental health input in general and psychology input in particular are not needed. Adhering to the spirit and the letter of the HEW Program Manual, the Massachusetts Psychological Association has continued to offer its assistance to Boston-area

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<sup>1</sup> The following organizations have endorsed this statement:

- American Association of Pastoral Counselors
- American Occupational Therapy Association
- American Pharmaceutical Association
- American Physical Therapy Association
- American Podiatry Association
- American Society of Hospital Pharmacists
- American Society for Medical Technology
- American Speech and Hearing Association
- National Association of Social Workers
- National Rehabilitation Counseling Association

PSRO's for mental health care criteria development. This generous offer of support, made in good faith, continues to be ignored by the local PSRO's. In New Mexico, on the other hand, psychiatry and psychology have worked together to develop a very comprehensive set of joint criteria standards for mental health PSRO review.

In Minnesota, a representative for psychology has been on an "Allied Health Provider Council" established to relieve non-physician anxieties about the activities of the Minneapolis area PSRO. While the liaison between the "Allied Health Provider Council" and the PSRO has been on the whole productive, psychology's access to the PSRO through the "Allied Council" does not take into account the profession's established status as an *independent* as opposed to an "allied" health profession. Psychologists, unlike some other non-physician professionals who may function as an extension of a physician or in a laboratory capacity, are fully trained to deal with behavioral problems not stemming from organic causes on an autonomous basis. Psychologists are also regularly involved in behavioral health care when organic causes are involved in conjunction with other care modalities delivered as part of a multi-disciplinary approach. Psychology insists that the Department of Health, Education and Welfare clarify the status of independent non-physician health provider groups in regards to PSRO planning and development.

In Alabama, psychologists have been told by local PSRO officials that they cannot be represented on the PSRO's Advisory Group. At the present time, only physicians are being admitted to the Advisory Group. Chapter XV, Page 1 of the HEW Program Manual states that Advisory Group membership "... shall include three categories of individuals: (1) *representatives of health care practitioners other than physicians*, (2) representatives of hospitals, (3) representatives of other health care facilities which receive reimbursement under titles XVIII, XIX, and V of the Social Security Act . . ." Furthermore, the purpose of the Advisory Councils, according to the Program Manual (Chapter V, Page 13) is "... to formally relate to health care institutions, *organizations*, or *health professional associates* for advice or assistance in carrying out the duties and functions of a PSRO." For whatever reason non-physician representatives have been barred from the Alabama PSRO Advisory Council, the net effect has been to directly block the kind of non-physician input into PSRO development that the Program Manual clearly states is not only important but necessary for HEW recognition.

In Ohio, Peer Review Systems, Inc., the Central Ohio Region PSRO, amended the HEW by-law model successfully without opposition from the Department of HEW. The PSRO's by-laws now restrict Board of Trustees (or Governing Board) membership to PSRO members only (physicians and osteopaths). The HEW Program Manual (550.13a) Chapter V, Page 14, states: "... the Governing Body shall be composed primarily of physicians performing special activities in the PSRO area and may include non-physicians from the designated PSRO area. Consumer representation on the governing body is encouraged." While the Program Manual criteria for governing body candidates are the same in the by-laws of the Central Ohio PSRO, the additional requirement that such candidates be members of the PSRO eliminate not only non-physician groups but consumer groups as well from Board membership. Membership in a PSRO is limited to physicians or osteopaths only. Support from the Department of Health, Education and Welfare in defense of its own PSRO operational standards has not been forthcoming despite pleas from Central Ohio psychologists and other non-physician groups.

While non-physician concerns over PSRO organization and operations can be voiced through Advisory Councils at either the PSRO level itself or the State-wide Professional Standards Review Council level, and while non-physician representatives can aspire (according to the Program Manual) to Governing Body/Board of Directors/Trustees membership, no such parallel mechanism of representation exists at the national planning level for PSRO. National organizations representing non-physician interests have been attending sessions of the National Professional Standards Review Council at their own expense, but they have been accorded little more than observer status at these important meetings. The American Psychological Association supported a joint proposal to the Council presented on behalf of twenty-three non-physician professional organizations, requesting that an Advisory Council of Non-physician professionals be created to interest with the National Professional Standards Review Council

on matters of concern to these groups. Neither the Council or the Department have responded directly to this endorsement although "continuing discussion" of the advisory council proposal has been promised by the Department. In the meantime, the Department has gone ahead with an interim proposal of its own. A voluntary liaison mechanism has been set up for the benefit of the non-physician groups. The non-physician groups are being asked to select one person to act as a "focal point" to expedite liaison between non-physician groups and the Department. The HEW liaison proposal does not provide an adequate mechanism for the sharing of information on subjects of inter-professional concern before such matters appear on the agenda of the National Professional Standards Review Council (to which there is no non-physician input). The establishment of a true National Advisory Council of Non-Physician Organizations would provide the Department and the NPSR Council with the ongoing non-physician input that is so clearly needed as the PSRO program is implemented. The liaison mechanism that has been recently established allows non-physician groups only the most cursory opportunity to have a hand in shaping policies that will one day have a very significant impact on their profession's functioning in the health market place.

In summarizing, we would urge that the Department of Health, Education and Welfare redouble its efforts to effect broad professional involvement in PSRO planning and development. The Department can see to it that the operational procedures outlined so clearly in the Program Manual are more closely adhered to at the local level. We ask also that the Department pay closer attention to the clear need for a true National Advisory Council for Non-Physician Organizations. Such a Council would allow non-physician groups to play an even more positive role in assisting the Department to fulfill the Congressional mandate on peer review. Our Association will continue to support the quality assurance objectives of PSRO peer review.

## APPENDIX

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### HEW RESPONSES TO OVERSIGHT SUBCOMMITTEE QUESTIONS ON THE PSRO PROGRAM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,  
*Washington, D.C., May 17, 1976.*

HON. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: Enclosed are the answers we have prepared in response to your request of March 3. We hope that our responses will be useful to you. We, as always, appreciate the opportunity to provide you with information and make our views known to your Committee.

Sincerely yours,

THEODORE COOPER, M.D.,  
*Assistant Secretary for Health.*

Enclosure.

*Question 1.* What was the original intent of the PSRO program?

The original intent of the PSRO program was to assure that the medical care delivered to beneficiaries of the Medicare, Medicaid, and Maternal and Child Health and Crippled Children Services programs is of high quality, and is provided in a manner which reflects the appropriate utilization of the Nation's health care institutions. PSROs were designed as a mechanism in which practicing physicians would be given full responsibility for reviewing quality and appropriateness of services.

*Question 2.* Are the goals of the program the same today? What changes, if any, have occurred?

The goals of the PSRO program today are identical to the original goals of the program.

*Question 3.* How can the PSRO program best accomplish these goals?

The PSRO program can best accomplish its goals by the continued implementation of the program. The first and most important requirement was to get physician participation in the PSRO program. Initially, there was medical resistance to PSRO, but now that physician acceptance of the PSRO program has grown, adequate funding is necessary for full implementation of the program. Prior to mid FY 1976, PSRO implementation was hindered by Congressional cuts in the budget. With the passage of the new financing amendment (P.L. 94-182) for the funding of hospital review, Conditional PSROs will now be able to expand review activities more rapidly and eventually initiate long-term care review. During FY 1977 we expect to fund 120 Conditional PSROs and 83 new Planning PSROs in order to cover all 203 PSRO areas. In addition, 10 Statewide Professional Standards Review Councils will be set up in those States having three or more PSROs. The sooner PSROs begin to perform binding review, the sooner existing ineffective and duplicative review systems will be replaced.

*Question 4.* According to a Library of Congress study on the PSRO program and the Senate Finance report on the Social Security Amendments of 1972, one of the objectives of the PSRO program is to coordinate the Medicare and Medicaid programs. Is this happening? How effective has this been?

PSRO's review health care services reimbursed by Titles V, XVIII, and XIX for necessity and appropriateness. They thus serve an important role in the conduct of these programs and must work closely with the State and Federal agencies which administer them. *PSRO's do not coordinate Medicare and Medicaid, but rather provide critical review services to Medicare and Medicaid.*

The administration of the PSRO program requires close coordination with Medicare and Medicaid since PSRO decisions on Medical necessity are binding on the Medicare and Medicaid fiscal agents.

Prior to the enactment of the PSRO amendment differing requirements for utilization review existed under the Medicare and Medicaid programs. Implementation of the PSRO program, because it is a uniform system of review for all Title V, XVIII, and XIX beneficiaries, has provided a strong basis for coordination among the programs. For areas where PSRO has not yet been implemented, the Department has developed new and improved utilization review procedures to be required under Medicare and Medicaid. These requirements, which were developed with interagency consensus with a view towards promoting coordination between the Medicare and Medicaid programs and at the same time providing a system of review, would enable hospitals to make an orderly transition from utilization review to PSRO review. The authority under which the new regulations are being promulgated flows from provisions in the Social Security Amendments of 1972 which were intended to strengthen and unify the utilization review requirements under the Medicare and Medicaid programs. These provisions were passed simultaneously with the PSRO provision.

*Question 5.* Why aren't the regulations on the PSRO program out? What is holding them up?

The development of regulations for PSRO is continuing, although problems have created delays. Policy and regulatory development has been a complex and time-consuming task, requiring extensive legal and technical analysis and intradepartmental coordination and decision making, because of the need to coordinate the existing statutory and regulatory review requirements of Titles XVIII and XIX with PSRO statutes. The PSRO transmittal system was developed to provide an expeditious method for communicating evolving policy to the PSRO projects. When policy has been fully developed and approved, it is then incorporated into a manual issuance which outlines acceptable program policy alternatives. Necessary legal and policy decisions have caused some delays. For example, the need for a legally sound decision on the authority of PSRO's during the conditional period delayed the "assumption" regulations, which describe the role and responsibilities of conditional PSROs. In addition, there have been legislative amendments (P.L. 94-182) which have necessitated immediate changes in existing regulatory language, thus delaying other sets of regulations.

Below is a tentative estimate of dates of publication of the notices of proposed rulemaking for PSRO regulations.

	<i>Date</i>
1. <i>Assumption of review authority</i> by conditionally designated PSROs.....	June 1976
2. <i>PSRO hospital review requirements</i> .....	July 1976
Part I—Review process.	
Part II—Delegation of review to institutions.	
Part III—Norms.	
3. <i>Hearings and Appeals:</i>	
Parts II and III—Reconsiderations and Appeals.....	July 1976
4. <i>Advisory groups:</i>	
Part I—Advisory groups to PSROs (Final Regs).....	June 1976
Part II—Advisory groups to Statewide Councils.....	June 1976
5. <i>Confidentiality</i> requirements.....	August 1976
6. <i>Statewide Councils</i> .....	June 1976
7. <i>Sanctions</i> .....	October 1976
8. <i>Agreements</i> .....	September 1976

#### PSRO REGULATIONS PUBLISHED

	NPRM	Final
1. PSRO area designations.....	Dec. 17, 1973	Mar. 18, 1974
2. Notification and polling procedures.....	Apr. 16, 1974	May 7, 1974
3. Advisory groups—Pt. I.....	May 6, 1975	
4. Interim hearings and appeals.....		Feb. 20, 1976
5. Statewide polls.....	Apr. 28, 1976	

*Question 6.* How does the Secretary plan to evaluate the effectiveness of PSRO activities?

Evaluation of the PSRO program has been a topic of interest to the Department since the enactment of Public Law 92-603. A PSRO evaluation plan has been developed with the assistance of outside experts and with the advice and approval of the National Professional Standards Review Council.

A key facet of evaluation is the PSRO Management Information System which will make available to the Department information which will be used both to monitor the activities of PSRO and to evaluate their impact. Using the approved plan as a guide and with the advice and assistance of other Departmental components, *we have begun to implement a PSRO evaluation strategy.*

Three special study topics will receive first attention. These are:

- (a) evaluation of the impact of concurrent hospital review,
- (b) evaluation of the impact of medical care evaluation studies, and
- (c) assessment of the impact of PSRO review on health care expenditures.

*Question 7. Is there a definition outlining successful PSRO activity?*

PSRO's are charged with the responsibility for assuring that services provided to Medicare, Medicaid and Maternal and Child Health patients are of a quality which meets *locally defined criteria* and standards of care, are medically necessary, and are delivered in the most appropriate health care setting. The degree to which a PSRO meets this objective will define its success.

The first priority of all PSRO's is the review of acute care hospital services. Concurrent review of such services will help to assure among other things that unnecessary hospital admissions are prevented and that lengths of stay are appropriate. Performance of medical care evaluation studies will help assure that needed services are provided and that the services delivered are consistent with quality medical care.

Because the quality of services and the appropriateness of their utilization varies from area to area, PSRO success must be measured against an appraisal of the degree to which there are quality and utilization problems currently existing in an area. Therefore, much of the evaluation which will be done in the PSRO program will be done on a PSRO-by-PSRO and hospital-by-hospital basis. With this approach we can more accurately measure the true success of the program and, as importantly, define successful and unsuccessful approaches to health care evaluation. In this manner evaluation can feed back into a redefinition of approaches to health care review which will result in consistent PSRO influence on the appropriateness of utilization and the quality of care.

*Question 8. Are there measures that are being taken to translate successful results from one PSRO to another that is not successful?*

A variety of measures may be taken to assist a PSRO in improving its performance:

a. Technical assistance is provided by the PSRO Project Officer and the Associate Project Officer. Project Officers typically serve several PSROs. Sharing measures used to achieve successful results by one PSRO with other PSROs is a common and accepted practice.

b. Meetings are held among all PSROs in a given DHEW-PHS Region for the purpose of providing mutual assistance among the PSROs in improving procedures.

c. In several states with multiple PSROs, the PSRO Executive Directors meet regularly to share common concerns and to assist each other in improving procedures. The same occurs among the Review Coordinator Supervisors.

d. Staff of the Bureau of Quality Assurance utilizes knowledge of successful review procedures in providing direct technical assistance to PSROs or indirect technical assistance through the PSRO Project Officer.

e. Consultative service to individual PSROs has been provided under contract. The majority of consultants are individuals involved in a PSRO program that has had success in the specific aspect of the program for which the recipient PSRO is seeking assistance. This form of expert assistance to PSROs will be expanded substantially in the near future.

f. Reports of Medical Care Evaluation (MCE) studies provide information for a clearinghouse of successful MCE study methodologies and successful criteria and standards. PSROs needing assistance in the conduct of MCE studies can receive information from this source.

g. Site visits to PSROs and PSRO Project Officers and other BQA staff are conducted periodically. Mechanisms employed by the PSRO can be explored in depth at those times. Where the PSRO has experienced success, the staff can draw upon that information to help other PSROs who have not achieved the same measure of success.

*Question 9.* Is it possible to evaluate a PSRO's effect on the quality of care? How is this measured?

One of the components of the PSRO review system is medical care evaluation studies, or medical audit. These medical audits are retrospective examinations of the quality of health care delivered to groups of patients with common characteristics. Through medical care evaluation studies, deficiencies in the quality of care can be identified. One component of any medical care evaluation study is a reaudit of the same subject at a point following the implementation of corrective actions to correct the deficiencies identified through the first study. Thus, through the reaudit, a concrete measure of the improvement in quality which has resulted from the corrective action can be made. PSRO evaluation will attempt to aggregate this information and at the PSRO level to correlate it with changes in health status outcome. In addition, health status indices offer an additional mechanism for measuring changes in the quality of care. With implementation of the new Health Planning and Resources Development Act (P.L. 93-641), many Health Systems Agencies will be working cooperatively with local PSROs to utilize such health status indices as a means for monitoring changes in the health status of populations over time. PSRO, of course, is one of several mechanisms operating in the community which will act to improve the health status of the population. Nonetheless, both health status indices and the results of the reaudit component of medical care evaluation studies will be valuable tools in measuring the impact of PSROs on the quality of health care.

*Question 10.* What effects are PSRO activities having on health care costs within the Medicare and/or Medicaid programs? On total health care costs?

A PSRO is primarily a mechanism for assessing the quality and appropriateness of medical care services which are delivered. Other elements such as financing systems, program coverage decisions and rate-setting mechanisms primarily address cost controls. While quality assurance activities of PSROs may increase the utilization of some services while decreasing that of others, we believe that in assuring proper utilization of services, the PSROs are likely to have a beneficial effect on costs. An effective PSRO program can assure that whatever Federal dollars are spent on health care will only be spent on appropriate quality care.

It is clearly too early to assess the true impact of PSRO activities. Very little data is available at present due to the short time that these organizations have been conditional and performing binding review. The Office of Management and Budget (OMB) has mandated a major evaluative effort which is now underway. Our early indications are that conditionally designated PSROs have found some evidence that where PSRO review is implemented, hospital lengths of stay are shorter than under previous conditions.

Several of the original 14 PSROs given conditional status prior to March 1975 were conducting PSRO type review prior to undertaking PSRO review; thus data as far back as 1973 is available on review which is very similar to PSRO review. Six PSROs (Multnomah, Colorado, Prince Georges, Montana, Mississippi and Minnesota) were able to provide data on average length of stay for federally reimbursed patients for at least 1974 and 1975.

The 1974 data on length of stay which preceded PSRO review was compared to 1975 data which followed the introduction of PSRO review. For the above mentioned six conditional PSROs reporting complete data, the average decrease in length of stay was approximately 6 percent, or half a day, hospitalization. A rough estimate of the hospital utilization cost savings for 1975 due to reduction in length of stay across the six PSRO areas can be estimated. Based on an average cost of \$100 for each day of hospitalization with an average reduction per admission of  $\frac{1}{2}$  a day of hospitalization, the estimated savings in hospital utilization costs for 1975 was 22.5 million dollars.

Length of stay data available from four newly designated conditional PSROs (South Carolina, Idaho, Hartford County and Greater Oregon) showed an average decrease of length of stay of 22.75 percent. For Medicaid patients, length of stay declined from 7.94 days to 5.68 days. At an average cost of about \$100 a day, the resultant rough estimate of the saving in basic hospitalization costs was approximately \$223 per episode of hospitalization. For Medicare patients, length of stay declined from 11.21 to 9.3 days. At a cost of \$100 per day, the resultant saving in basic hospitalization costs can be estimated to be approximately \$189 per episode of hospitalization.

We wish to emphasize that to date, no exhaustive study has been completed. The data we have provided you is preliminary.

The PSRO program is mandated to review the care only of Federally insured beneficiaries under Titles V, XVIII, and XIX of the Social Security Act. Whatever the impact of the program on total health care costs is, it will be indirect. We currently have no data available on what such indirect effects might be but hope that the positive trends reflected within the Medicare and Medicaid programs from PSRO review can tangentially impact on private health care costs.

Full implementation of PSRO hospital review is expected to cost approximately \$200 million per year. To date, the limited data we have received indicates that there is a cost benefit to investments in PSRO review. In some areas the average saving has been a one-to-four ratio. Our evaluation efforts should yield better data.

*Question 11.* Is the PSRO program expected to reduce expenditures within Medicare and/or Medicaid? What are the projections of savings over the next five years? How much money will be spent on the PSRO program over the next five years to acquire these savings?

Any assessment of the PSRO budget must be conducted in terms of the Department's overall costs for required hospital review of Medicare and Medicaid admissions, including PSRO costs and Medicare/Medicaid utilization review costs.

As PSRO costs increase, utilization review costs decrease. As the PSRO budget goes up, the Medicare and Medicaid utilization review (and eventually benefit costs) budgets go down.

During FY 1977, it is estimated that as a result of this trade off, the net increased cost to the Department for PSRO review will be less than the \$62 million budget request.

Early data from PSROs regarding impact indicates that conditionally designated PSROs have found evidence that where PSRO review is implemented, hospital lengths of stay are shorter than under previous conditions and numbers of unnecessary admissions are reduced as well.

*Question 12.* It might be expected that immediately after a PSRO program begins to operate that blatant overutilization of facilities and services would be halted. This would result in an immediate visible dollar savings. However, when the blatant overutilization is eliminated and we continue to monitor for overutilization, will the costs for continued monitoring be greater than the actual savings? Do you have cost saving figures from the earliest PSROs which might indicate such a pattern?

Our cost impact data on hospital length of stays indicates that this pattern of decreasing reductions in lengths of stay over time with PSRO review does occur. The more startling rate of change for length of stay among new conditionals, twenty-two percent as compared to six percent for the original conditionals, is a function of their state of development. Changes in length of stay relate to the degree of overuse present when review starts. Overuse may be low or high, but it is less likely to be high when a PSRO has been in place for some time. Therefore the larger changes in length of stay may be expected when review is first implemented. We have not collected evidence of widespread "blatant overutilization." We do not yet have figures that indicate that the subsequent reductions in hospital lengths of stay over time are so low as to be less than the cost of continued PSRO monitoring. Furthermore, it is important to note that the preventive function of continued PSRO review toward keeping lengths of stay the appropriate minimum cannot be quantified. Additionally, it is anticipated that the costs of PSRO hospital review will decrease over time as the system is refined through operating experience and the continued development of profiles, and Medical Care Evaluation studies.

*Question 13.* Will the costs of operating a hospital come down as a result of PSRO review?

It is difficult to determine whether the costs of operating a hospital will come down as a result of PSRO review. While PSRO review is recognized as a more efficient review system than most existing systems, efforts are directed at review of patient care and not necessarily at administration or management of the hospital itself. It is possible that a decrease in hospital operating costs in general could be realized as a result of improved efficiencies. However, it is also possible that costs per individual patient could increase due to less utilization of beds within the hospital and the fact that as a result of PSRO review, the patients remaining in the hospital will be more seriously ill, requiring more expensive treatments, etc. This of course requires close coordination between PSRO and the new planning agencies.

*Question 14.* Have the admission rates to hospitals changed as a result of PSRO review?

The limited data we have received from some PSROs regarding reductions in unnecessary admissions indicates that admissions are reduced from 1-3 percent as the result of using a concurrent review system. At an estimated hospital cost of \$100 per day, and given about 11 million Medicare and Medicaid admissions annually, the potential savings from reductions in unnecessary admissions are significant.

*Question 15.* If through PSRO review, we are able to cut down the number of days individuals spend in a hospital, this would create additional empty beds per day. Are beds lying unoccupied that once were filled with patients? Are hospital admissions increasing to fill these beds?

Because of the short time PSROs have been performing binding review, very little data is available at present regarding an increase or decrease in the number of unoccupied beds or an increase or decrease in admissions as a result of PSRO review. However, cooperation between PSROs and the recently mandated Health System Agencies (HSAs) will help to avoid such increases in the number of unoccupied beds and admissions as the result of PSRO review. HSAs are designed to provide effective health planning for the area, promote the development of needed health resources, and reduce resource inefficiencies.

*Question 16.* What is the definition of professional standards? Does each PSRO create its own definition?

The provisions of Section 1153 of the Social Security Act speaks to the use of "professionally developed norms of care, diagnosis and treatment" which have been interpreted by the Department to be norms, criteria and standards. These norms, criteria and standards must be applied by PSROs as principal points of evaluation in the review of health care services provided in hospitals to Titles V, XVIII, and XIX patients.

"Norms" mean numerical or statistical measures of usual observed performance of health care activities.

"Criteria" means predetermined elements of health care, developed by health professionals relying on professional expertise, prior experience and the professional literature, with which aspects of the quality, medical necessity, and appropriateness of health care services may be compared.

"Standards" mean professionally developed expressions of the range of acceptable variation of performance from a norm or criterion.

Norms, and criteria can be used as screening tools by a nonphysician because they allow for selecting out from a large number of cases being reviewed, a small number for which physician review is appropriate. They do not define rigid standards of quality and lengths of stay. In other words, if a case fails to meet screening criteria, it does not necessarily mean that poor quality care was delivered to that patient. It is intended only that, under those circumstances, physician review should be required.

These definitions apply to all PSROs and thus each PSRO does not create its own definition.

*Question 17.* How are norms agreed on within a PSRO area?

Sample sets of norms, criteria and standards will be distributed by the *National Professional Standards Review Council* and will be used as principal points of reference by each PSRO as they establish norms, criteria and standards for their area. The PSRO should establish an appropriate committee or sets of committees for the purpose of using as guidelines these sample norms, criteria and standards in establishing their own norms, criteria and standards.

In selecting members for these committees, the PSROs generally attempt to provide balanced representation from the medical staffs of the hospitals in their area. To the extent possible, the committee(s) should be so constituted as to allow each major specialty to review the norms and criteria for its specialty.

*Question 18.* Do norms vary much from the one PSRO to the next? What accounts for the difference?

Norms, criteria and standards have not varied greatly from one PSRO to the next.

Variations which do occur may be due to a difference in the demographic characteristics of the population the PSRO serves, unusual or complicated diagnoses and problems in the patient population (e.g., a PSRO having large referral centers), an honest professional difference in the type of treatment modality for a given diagnosis or problem in cases where no definitive therapy has been

developed, availability of alternative levels of care (e.g., skilled nursing care facilities), and differences between rural and urban settings where care in a rural area may not be accessible.

*Question 19.* Has the idea of setting norms met with resistance from doctors?

Physicians have been very cooperative in developing norms, criteria and standards. The Department of Health, Education, and Welfare has a contract with the American Medical Association to develop sample sets of criteria for use by PSROs. The American Osteopathic Association has also developed criteria for use in osteopathic institutions. Conditional PSROs have adopted or adapted various criteria sets, including the AMA's and those from Medical Societies and Medical Care Foundations, or developed their own criteria. The Department and physicians believe that, criteria are not cookbooks that must be rigidly adhered to and which contain every possible variation and combination of therapeutic modalities for a given disease entity. To use criteria in this way would preclude innovation by a physician in the care of his patient.

*Question 20.* Is there any coordination of criteria that establishes standards of acceptable medical quality care between one PSRO and another?

Each PSRO is to establish norms, criteria and standards which reflect typical patterns of practice in the PSRO.

Sample norms, criteria and standards will be distributed by the National Professional Standards Review Council and will be used as principal points of reference as the PSROs establish the norms, criteria and standards for their area. In addition to its responsibility to distribute sample norms, criteria and standards, the National Council will be analyzing the appropriateness of significant variations among norms, criteria and standards used by the PSROs. As specified in section 1156(a) of the Social Security Act, when the National Council determines that the significant variation in a PSRO's norms, criteria or standards is inappropriate, the PSRO may not use that norm, criteria or standard until the variation is justified or the norm, criteria or standard is changed.

*Question 21.* According to a Library of Congress study of the PSRO program, in FY 77 it will cost \$69 million to review approximately three million of the total 11 million Medicare and Medicaid cases. When will the PSROs be reviewing all Medicare and Medicaid patients? Is the cost of the program expected to quadruple when all Medicare and Medicaid patients come under it? How much is the program expected to cost when all patients are being reviewed?

The PSRO President's Budget request for FY 1977 calls for funds to support 120 conditional PSROs, 83 new planning PSROs, and 10 Statewide Councils. Approximately 3 million Medicare/Medicaid hospital admissions will be reviewed, and the cost for this review will be about \$69 million. It is expected that PSROs will be reviewing all 11 million Medicare and Medicaid hospital admissions during fiscal year 1980 and at a cost of about \$200 million.

The cost of PSRO hospital review is not expected to quadruple as reviews are increased to cover all 11 million Medicare and Medicaid admissions. It is anticipated that the cost per review will begin to decrease as the review process becomes more refined through experience. The development of profiles and the results of medical care evaluation studies are expected to contribute to a reduction in costs per review through focusing review on problematic areas. However, it must be recognized that PSROs are also responsible for the conduct of long term care review and, on an optional basis, ambulatory care review. Both of these elements are expected to increase the costs of the program substantially. As part of the overall review program, we expect that long term care review will be continued.

Full implementation of PSRO hospital review as expected to cost approximately \$200 million per year. Any assessment of the PSRO budget must be conducted in terms of the Department's overall costs for review of Medicare and Medicaid utilization review costs. PSRO expenditures offset in part expenditures for utilization review under Medicare and Medicaid.

*Question 22.* How were the boundaries of the PSRO areas decided upon? Have there been changes in the boundaries since the initial designations?

The Department initially consulted with State and local medical groups and other professional groups in local areas; their advice helped determine area designations which would facilitate the successful application of the PSRO legislative objectives. Proposed rules, including the guidelines for area designation, were published in the *Federal Register* September 20, 1973. The following 45-day-period provided an opportunity for comment on those rules. The final

regulations were published on March 18, 1974 after consideration of the comments received. Six guidelines were utilized in the designation: (1) PSRO areas should not cross State lines and (2) generally should not divide a county. (3) The designation of PSRO areas should take into consideration the existing boundaries of other medical review organizations. (4) To the extent possible, PSRO's are to coincide with a medical service area and assure broad, diverse representation of all medical specialties. (5) A PSRO should generally include a minimum of 300 licensed, practicing physicians and generally should not exceed 2,500. (6) Also taken into account was the need to allow effective coordination with Medicare/Medicaid fiscal agents.

To date there have been no changes in the PSRO area boundaries, however, the Secretary published in the *Federal Register* of March 26, 1976, notices of proposal to change the Minnesota and Tennessee PSRO areas. Comments have been received and appropriated action will be taken on the comments before final notice of redesignation is published.

*Question 23.* Are the PSRO and HSA boundaries identical? How many are not? What accounts for this difference?

There are 123 congruent boundaries and 80 boundaries which are not congruent. Congruent is used to mean that PSRO boundaries are identical with, totally subsume multiple HSA areas, or are totally subsumed within an HSA boundary. We feel that congruency is more important for effective working relationships than actually having all the areas identical.

The timing of each legislative act, differences in Congressional jurisdiction, and substantive considerations relating to the functioning of each agency were important factors in the geographic incongruity. Specifically, the differing legislative objectives and guidelines for HSA and PSRO areas makes identical boundaries impossible in most cases. For example, PSRO areas do not cross state lines as the medical program is State based, while 15 HSA areas are interstate in order to include the complete medical service area. Similarly, PSRO's are based on the concept of local peer review, while HSAs require a geographic area containing basic specialized health services.

Both HSA and PSRO guidelines call for compatibility with each other's areas "to the maximum extent feasible" but it was recognized that other priorities for designation might create differences.

Is there an advantage to having two different boundaries?

What disadvantages would there have been if HSAs and PSROs shared the same boundary system?

It can be helpful for HSA and PSRO boundaries to be the same to facilitate cooperation between them, for example, to coordinate the flow of information needed by both. However, the differing legislative objectives for both programs make it impractical for all HSA and PSRO areas to be the same. In such situations it is often possible to have congruent, if not the same, HSA/PSRO boundaries which also promotes a good working relationship between the two organizations. However, in some areas, the differing objectives of the two organizations make it infeasible to have congruent boundaries for their areas.

Having multiple HSAs within a PSRO area or multiple PSROs within an HSA area may prove to be an advantage in providing HSAs and PSROs a basis for comparison between areas. By providing multiple sources of data, this will provide a broader view of utilization and patterns of care. The PSROs and HSAs believe that their respective bases of support (i.e., practitioners and consumers) would be much more substantial if the present boundaries of each are maintained.

The only possible disadvantage in having the same or congruent boundaries would be if such boundaries were established solely for the purpose of having identity or congruency and did not take into consideration the differing objectives of the PSRO and HSA programs. It should be noted that where in the future PSRO areas are changed, we will attempt to maximize effective, coordinated relationships between PSROs and HSAs by providing congruent boundaries, where legally feasible and operationally desirable.

*Question 24.* How long are most PSROs remaining in the planning stage? Are any taking over a year? How many are? What accounts for the discrepancy between a PSRO that sets up its planning stage in six months and one that takes over a year?

On the average, a planning PSRO requires about 12 months to accomplish the tasks necessary for qualifications as a conditional PSRO. Once the tasks have been accomplished, an additional 2-3 months are required for the notification and polling process.

Actual experience has shown that of the 91 original planning PSROs, 39 required extended contracts of an additional year due to budgetary and other problems.

There are several factors affecting the length of time a PSRO remains in the planning stage. Many of the initial planning contracts went to already existing organizations and thus it took less time for them to become functional than newly organized PSROs. The amount of State cooperation and hospital and physician participation and cooperation with the PSROs affects the time needed to perform the required tasks.

Additional time in the planning stage was required for many of the initial PSROs due to lack of funds for conversion. The new financing amendment and increased budget request for FY '77 has allowed more rapid progress and most of the now existing planning PSROs will convert to conditional by the start of 1977.

*Question 25.* What must a conditional PSRO do to achieve permanent status? When will the original PSROs reach this point? What will happen to the fourteen original PSROs if they do not meet permanent status requirements by the end of two years?

For a PSRO to be designated operational, i.e., permanent, it should have had reasonably extensive experience with, and capably performed, both acute hospital and long term care review under an approved plan. In the case of hospital review, the PSRO must have binding authority for both Medicare and Medicaid claims payment. While the original PSROs are performing well, none have as yet implemented review to the extent believed necessary for operational designation. In addition, some PSROs have taken more time to become functional due to difficulties in the development of working relationships with the Medicare and Medicaid fiscal agents and the hospitals in their areas.

It has been determined, in conjunction with the Department's legal counsel staff, that it is possible to redesignate an organization on a conditional basis for a period of up to an additional twenty-four months. The General Accounting Office (GAO) had initially raised concern about this opinion. After discussing the matter, however, the GAO concurred that it was an allowable and necessary approach. Therefore, the Bureau of Quality Assurance will redesignate as conditional all of the original PSROs. It is anticipated that most of the projects will be designated operational prior to the end of their second conditional period.

Early in FY 77, the Bureau plans to develop and test with those original PSROs a mechanism for determining whether the performance of a PSRO warrants its conversion to operational status.

*Question 26.* If a PSRO decides that a patient's hospitalization was unnecessary and will not allow Medicare or Medicaid reimbursement, is the patient liable for his hospital and doctor bills? Does the patient have any legal recourse against his physician?

Section 1153 of the Act prohibits Federal payment for services which a PSRO finds in the course of its review are not medically necessary except where the Secretary determines the claimant is without fault. Under Medicare there is a provision (Section 1879) which enables the Department to relieve the patient of liability for hospital services if the patient did not know or have reason to know that the services were not medically necessary. The Medicare waiver of liability provision has, on an interim basis, continued to be applied to claims denied by PSROs. It is expected that PSRO regulations governing the implementation of the "without fault" provision in Title XI will incorporate the substance of the Medicare provision. There is no provision in the PSRO legislation which provides legal recourse for a patient against his physician if a PSRO decides that a patient's hospitalization was unnecessary. Of course, a patient's right to pursue a malpractice action remains unaffected by the PSRO provision.

*Question 27.* If a physician is fined by a PSRO for overutilizing facilities or providing a patient with unnecessary treatment, who is liable for the fine? Can the doctor bill the patient for the fine? If this is the case, does the patient have any legal recourse against such action?

Under the PSRO legislation physicians and other persons providing health care services which are eligible for reimbursement under the Social Security Act have certain obligations to assure the appropriateness and quality of medical services which they deliver and to provide documentation of such appropriateness and quality as the PSRO requires. If a person is found to have failed to meet these obligations, the Secretary of the Department of Health, Education, and

Welfare may exclude the practitioner or terminate other persons from participating in the program on a reimbursable basis either permanently or for a shorter period, or may, in specified situations impose a monetary penalty. The monetary penalty or "fine" permits the Secretary to require a practitioner or provider to repay an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services, not to exceed \$5000.

Individual PSROs do not have any authority to fine a practitioner or institution. Individual patients are not legally liable for payment of the fine. If a patient went to a physician or institution which had been excluded or terminated from eligibility for reimbursement, and had no knowledge of the exclusion, the Department would pay. However, the patient would be notified that subsequent cost incurred by such a practitioner or at such an institution would not be reimbursed by the Department. In these cases, the individual patient would be liable for this costs.

*Question 28.* What is responsible for the postponement of the initial deadline, January 1, 1976, for the establishment of PSROs by physicians at which time, if the physicians in each PSRO area had not established a PSRO program, a group of nonphysicians who were qualified to conduct PSRO reviews would be allowed to set up a similar system? What is being done to ensure that another postponement does not occur?

The Medicare Amendments of 1975 (P.L. 94-182 Section 108) signed by the President on December 31, 1975 extended the statutory preference given to physician organizations, and extended the requirements for notification and polling. The limitation on the Secretary's authority to recognize any organization other than a physicians' association as a PSRO has been extended from January 1, 1976 to January 1, 1978.

Since the PSRO President's budget request for FY 1977 will support 120 conditional PSROs and 83 new planning PSROs, it is anticipated that PSROs will be established in all 203 PSRO areas by January 1, 1978 and that another postponement will not occur.

*Question 29.* Have there been any cases where the doctors have formally opposed (voted against) the establishment of a PSRO, so that the Secretary may have to design one under Section 1152(b) (1) B? How many cases have been like this? What has been the outcome or will be the outcome? Are there regulations relating to Section 1152(b) (1) B?

There has been one case, San Mateo PSRO in California, where physicians in an area have voted against a specific PSRO under Section 1152(f) of the Act. Subsequently, no organization has been designated conditional in that area. The Department is currently examining these situations to determine the best course of action. No regulations have been issued to date relating to Section 1152(b) (2) (B), but the Department is currently working on developing these regulations.

*Question 30.* Will there be any difficulty in meeting the startup deadline on January 1, 1978, as defined in Section 108(a) of P.L. 94-182?

The FY 1977 President's budget request for PSROs will support 120 conditional PSROs and 83 new planning PSROs. Therefore, it is not expected that there will be difficulty in establishing PSROs in all 203 areas by January 1, 1978.

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## PSRO RESPONSES TO OVERSIGHT SUBCOMMITTEE QUESTIONS CONCERNING EXPERIENCES WITH HEW'S ADMINISTRATION OF PROGRAM

GREATER SACRAMENTO PROFESSIONAL  
STANDARDS REVIEW ORGANIZATION  
Sacramento, Calif., May 7, 1976.

MR. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.*

DEAR MR. VANIK: This letter is written in response to your letter of 22 March 1976 regarding our experiences thus far as a conditional PSRO. We appreciate this opportunity to comment on the program and hope our comments are of value to your subcommittee's inquiry.

Let me state initially that I feel our relations with DHEW have been open and cooperative. As with any new program there is going to be a certain degree

of misunderstanding and confusion initially. However, it is our feeling that this period has since passed and things are now operating as smoothly as possible.

The system of transmittals caused us some concern initially because of the resulting imposition of regulations through this mechanism. BQA has now relaxed its tight control in this area and allows a more free and open exchange of ideas before they are published in final form. Looking back, it is our feeling that this tight rein was probably good for the overall direction and success of the program and got it off on a strong footing. As we and other PSROs gain more experience, the continued exchange of fresh ideas will be a necessary ingredient for the continued development of the program.

Probably the one area that has caused us the most concern has been reimbursement of our monthly vouchers. Not only does it take what seems an inordinate amount of time to receive our money, but there were differences of opinion on what was required in the form of documentation before the contracting office would process our vouchers. Most of these problems have now been reconciled and we expect they will be totally resolved in a short period of time. The main problem probably lies in our belief and desire that we should be treated as a private corporation, not as a separate arm of the government. Whether this philosophical difference can ever be totally resolved remains to be seen, but the government has shown signs of flexibility and cooperation which we trust will continue in the future.

The divergent roles and responsibilities of the Project Officer and Contracting Officer has been the source of some frustration in the past. With one exception, our relations and rapport with our Project and Contracting Officers have been good. While differences have naturally occurred, both sides have always profited by the discussions and come out with a greater level of understanding of the other's position. Administrative concerns and goals are handled through the project officer while financial questions are fielded by the contracting officer. It is this split of roles that has caused the frustration. Recently, more regional decentralization was proposed by DHEW and should become a reality by the end of this summer. However, it is our feeling that this may not resolve problems that occasionally arise when we still have to deal with a contracting officer from Rockville, Md. Geographically, this is unrealistic. It is our hope that eventually we can work with and resolve specific questions with one person who has authority on a regional and overall basis. If we were to have one suggestion for improvement this would be it.

In response to your question regarding the improvements on the quality of care in the Sacramento area, I firmly believe our Certified Hospital Admission Program (CHAP) has a record of success unparalleled in the United States. Much of the utilization control mechanisms incorporated in the PSRO legislation were based on the effectiveness and acceptability of CHAP for both Medicaid and private insurance programs in the Sacramento area. The PSRO, as a natural continuation of this program, has simply continued this record of success. Financially, it has been reported that CHAP saved \$25,642,680 during the period April to December 1970. Lengths of stay have stabilized, due to the presence and acceptance of the program in our community since 1969. These were drastically reduced even before the implementation of the PSRO but the same dedication to quality has been retained. Specific documentation can be easily provided to further substantiate any of these claims.

The PSRO program is a major necessary advance in assuring quality of medical care without unnecessary utilization and expense. We feel that we now have a good relationship with the federal organizations involved with the PSROs. The magnitude of the program and the many variations in custom and acceptance throughout the country has caused major problems to both DHEW and local PSROs. At this time I feel that the government is developing both the accountability and the local flexibility as provided in the PSRO law.

I have been actively involved with this program since our initial testimony for the Senate Finance Committee. Physicians are very interested in demonstrating that peer review can improve quality and reduce the costs of medical care.

However, in your analysis of PSROs it is important to realize that:

1. Cost savings will be overshadowed by increasing costs of medical care due to new expensive life saving procedures, inflation and massive increases in cost of malpractice.
2. Any program needs time and experience to prove its validity.

This makes it all the more important to have an effective PSRO peer review mechanism. Although the Greater Sacramento PSRO has only operated under a conditional contract for one year, we have continued the excellent record established by CHAP. That is not to say that this first year has not had its frustrations, as we have tried to point out briefly in the preceding discussion. On the whole, however, our relationship with BQA has been open, cooperative and shows every indication of continuing to improve in this regard.

We are always willing to provide any PSRO information or advice to you or other committees or members of the Congress. I do not believe that changes in the law are needed now. It is imperative that Congress provide adequate funding to permit PSROs to function effectively throughout the country. It is likewise imperative that DHEW and local physicians and their PSROs be given adequate time to make this program operational and effective.

Please let us know whenever we can be of further assistance to you.

Sincerely,

JAMES C. BRAMHAM, M.D.  
Chairman, Board of Governors.

SAN JOAQUIN AREA PROFESSIONAL STANDARDS REVIEW ORGANIZATION,  
Stockton, Calif., April 5, 1976.

Hon. CHARLES A. VANIK,

Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S.  
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN VANIK: This is in response to your letter of March 22, 1976, requesting information on our organization's experiences in implementing and operating its PSRO review programs.

As you know, the H.E.W. agency chiefly responsible for PSRO program development and operations is the Bureau of Quality Assurance (BQA). In view of the massive task of implementing a complex program in 203 diverse areas throughout the nation in the midst of serious budgetary constraints and inter-agency and Federal-State coordination needs, it is our opinion and experience that BQA has been proceeding in a commendable fashion, particularly in its efforts to maintain the all-important but delicate balance between the flexibility which is essential for successful PSRO activity and the program integrity and evaluation needed for proper administration. It is our feeling that questions regarding H.E.W. guidelines can best be evaluated in terms of the above framework of the complex task faced by BQA and the considerable degree of success obtained so far.

The creation of BQA as the H.E.W. agency for day-to-day administration and development of the PSRO program was based among other things upon a concept of separating medical peer review and quality assurance activities from the health program payment agencies, and thereby developing a more identifiable, distinct and comprehensive review function through effective peer review managed by physicians of a local area. We believe that this concept of a distinct H.E.W. agency responsible for PSRO is still sound, and is in fact an important factor in the success of the program.

San Joaquin Area PSRO maintains a file on its concurrent quality assurance activities, with specific instances of improved quality of care through PSRO review. Selected examples from these files are enclosed for your information. Also enclosed is an excerpt from testimony presented at a recent hearing before the Subcommittee on Health and Environment, which describes San Joaquin Area PSRO's impact upon the proper care of tuberculosis in our five-county area.

Since the majority of PSRO's now existing have been designated only recently, the suggestion for Congressional hearings on the PSRO program could be premature and would be more useful after there has been time for valid conclusions to be made on the basis of accumulated program data through operational experience.

Please let me know if I can be of further help.

Yours sincerely,

DANIEL P. SHEEHY, Ph. D.  
Executive Director.

Enclosure.

CONCURRENT QUALITY ASSURANCE, SELECTED CASE EXAMPLES, JULY THROUGH  
DECEMBER 1975, SAN JOAQUIN AREA PROFESSIONAL STANDARDS REVIEW  
ORGANIZATION

In a small mountain community hospital an SJPSRO nurse coordinator was doing a medical records review of a patient with the admission diagnosis of "probable myocardial ischemia", and she discovered an EKG report that had arrived after the patient had been discharged (2-day hospital stay). The report stated "Changes are compatible with subendocardial myocardial infarction in antero-septal area". The nurse coordinator gave the information to the medical records librarian who in turn contacted the attending physician and gave him the report. The patient was called back to the hospital and at the time of this report was currently being evaluated and treated.

A nurse coordinator was reviewing an 80 year old man who had had numerous acute care admissions prior to PSRO review. She noted that the admissions were due chiefly to taking medications incorrectly. Each time, the attending physician had tried to persuade the patient to be admitted to a nursing home, but the patient refused. The nurse coordinator suggested that a Public Health nurse visitation to supervise medications might alleviate the numerous admissions, and she informed the attending physician regarding procedures for making such a referral. This matter was accomplished and to date the patient has not returned to the hospital.

In a small mountain community with only two convalescent hospitals, a patient with an extensive decubitus ulcer had been treated surgically at the only acute care hospital. The attending physician felt that the patient could be cared for at a lower level of care, but was extremely hesitant about sending the patient back to the nursing home where she had developed the decubitus ulcer. He told the PSRO nurse coordinator that in the past the nursing home had been unable to provide the highly skilled level of nursing care required by this type of patient and that the particular supplies requested by him for the care including certain types of packing and dressings, were not provided. The nurse coordinator informed the attending physician that the other convalescent hospital in the area did have a vacancy that day and suggested that the patient be transferred there for the skilled nursing level of care and then returned to her former residence when she no longer required that high level of care. The physician felt that this was an excellent idea but in spite of his persuasion the patient's family would not agree to allow the patient to be moved to a different facility. The nurse coordinator, before bringing the case to review for a decision on decertifying acute care, decided to discuss the problems regarding this transfer with the administrator of the original nursing home. Since the facility was licensed to care for Medicare patients, she questioned why they would be unable to provide the reasonable skilled care requested by the physician. As a result of her pursuance of this matter, the administrator of the facility agreed to provide all supplies necessary. Registered nurses from the acute care hospital volunteered to supervise the patient's daily dressings until they were satisfied that the facility's nursing staff were carrying out the physician's orders correctly. Though this solution might not be possible in other areas, it worked out very satisfactorily in this small mountain community for the patient, the family, the attending physician and the facility.

A 53 year old man with multiple admissions over the past several years was readmitted to one of the small mountain community hospitals with his usual admitting diagnosis of lumbosacral strain and lumbar myositis. On each admission the treatment had been pelvic traction and injections of pain medication I.M. every 3 to 4 hours. The patient had been totally disabled at home because of pain and at home was taking both oral and injectable pain medications. He was ambulatory and his affect at times seemed inappropriate to the pain he described. The nurse coordinator discussed the case with the attending physician and asked the attending physician if he was familiar with a certain hospital in a large urban area some miles away with a "Pain Center". The physician stated that he had heard of the Pain Center and did not know too much about it. The nurse coordinator was familiar with the care given there and told the physician about it. The physician did suggest this idea to the patient who seemed receptive. The patient was discharged after a 6-day stay to the Pain Center.

A 66 year old Medicare patient had been admitted to a large hospital with the diagnoses of diabetes mellitus uncontrolled and infection of foot and ankles.

After several days and three extensions of length of stay, the nurse coordinator became concerned regarding the deterioration of the patient's condition with no resultant change of treatment. She reviewed the case with the physician reviewer not for length of stay but for quality of care. The reviewer felt that this exemplified poor medical management and had the Medical Coordinator informed of the situation. The Medical Coordinator in turn referred the matter to the Chief of Medicine at the hospital. Within a day or two an orthopedic consultant and an endocrinological consultant had been called into the case. Changes in treatment were made and a surgical procedure was performed. Two-and-a-half weeks later the patient, greatly improved, was transferred to a lower level of care.

[Excerpt from testimony of Dr. Robert Van Hoek, Acting Administrator, Health Services Administration, before the Subcommittee on Health and Environment of the Committee on Interstate and Foreign Commerce, Wednesday, February 18, 1976.]

[NOTE.—Edited by Oversight Subcommittee staff to avoid duplication.]

In addition to information on the impact of PSRO hospital review, we have received some information on Medical Care Evaluation studies which have been conducted by the PSROs and the effects on institutional care and medical education.

In the San Joaquin Area PSRO, a transfer of Medicare patients with tuberculosis to long-term care facilities resulted from concurrent review and criteria development. It was the community practice, while such a patient was in an acute facility, to require three negative cultures before transfer to a long-term care facility. However, each culture required six weeks with two week intervals. Thus, patients would be in an acute facility for about 22 weeks before transfer to a long-term care facility. The long-term care facilities insisted on this because of fear of losing their licensure and fear of infecting other long-term care patients.

The PSRO brought together representatives of the long-term care facilities, the County Public Health Department, the acute hospital discharge planners and most important local pulmonary disease specialists. It was generally agreed that no culture was necessary and only two smears were needed, one at the beginning of treatment, and one showing decrease in bacteria count after treatment. Therefore, stays for tuberculosis in acute hospitals have been reduced from twenty-two weeks to two weeks. Further, while some patients go to a long-term care facility after two weeks, many can be sent directly home on medication.

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CALIFORNIA AREA XX,  
PROFESSIONAL STANDARDS REVIEW ORGANIZATION,  
*Sherman Oaks, Calif., April 30, 1976.*

CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN VANIK: In response to your letter of March 22, 1976 I am submitting the following specific answers to your questions. Being, as you recognize, a relatively new PSRO and still in the planning stage, I am not able to answer in depth some of the questions which you ask. However, there are some areas covered in your letter to which I think I can respond intelligently at the present time. This letter is being written as an individual and not in the name of the Board of Directors of California Area 20 Professional Standards Review Organization.

I will list the questions which you asked and attempt to deal with each of them in turn:

1. Difficulties with HEW

A. Clarity of guidelines.—There has been no significant difficulty with clarity of guidelines in terms of understanding. However, we have frequently been confronted with changes in guidelines after the fact. Having often spent many hours in preparing required materials, according to guidelines in the PSRO program manual and letters of transmittal available to us, we have been confronted with changes in these guidelines and directives made after the submission of some of these materials, requiring duplication of effort.

B. Promptness of reimbursement.—No problems.

C. Exchange of information.—There have been some serious problems in this area. On a number of occasions, after we have been under the impression that

our Board, our Administrative staff, the members of the personnel of the Regional Office of HEW in San Francisco, and the personnel of the Bureau of Quality Assurance in Rockville, Maryland, and most specifically our Project Officer, have all understood and agreed upon certain conditions and courses of action, we have found that decisions have been made contrary to our expectations at the level of the Bureau of Quality Assurance with no prior discussion with or notification of us or the Regional Office. Some of the decisions have been used on erroneous data and have resulted in a considerable amount of confusion and time wasting effort to clarify things which should have been dealt with prior to the rendering of decisions.

My suggestions for improving HEW's supervision of the program would primarily involve further decentralization of the supervision mechanism. The problems of geography, local economics, varying patterns of practice, differences in population, differences in types and numbers of hospitals, differences in availability of various types of medical services throughout the United States (and even within a state the size of California with several large metropolitan and rural areas) make it impossible for people in a central office in Washington or Maryland to be aware of the problems and the needs of the patient and physician populations of any given PSRO area or region. It has been our experience that the people in the Regional Office in San Francisco are more aware of the nature of our Area and more capable of dealing with our problems, as well as protecting the interests of the government, by seeing that this program is appropriately implemented to carry out its designed purposes. I believe that if more responsibility and authority were vested in such regional centers, the entire PSRO program could be implemented more efficiently, more economically and more expeditiously.

Another important consideration is the fact that at the present time it is necessary for us to work out all of our implementation plans for the PSRO as regards criteria of appropriate medical care, mechanisms for review, etc. with the Bureau of Quality Assurance. At the same time we are required to negotiate our budget with the Contract Division of HEW. The people in the Contract Division are, by their own admission, totally unfamiliar with the PSRO program and, therefore, find it very difficult to understand the budgetary requirements of a PSRO. This necessitates a complex three-way negotiation between the PSRO, the Project Officer and the Contract Division. If there could be some decentralization of this aspect of the program as well, and if this part of our program could be incorporated into the regional center, so that the entire program were dealt with as a single package rather than as two separate entities, one administrative, the other economic, I believe that things would work more efficiently and we could arrive at more appropriate solutions.

## 2. Hopes and Fears for the Program

A. My hopes for the program are probably very much the same as those of the people who put the program into law in the first place. I hope that out of this program will come improved quality of medical care for a greater number of the citizens of this country. I hope that out of this program will come a more reasonable and realistic cost for quality health care. I hope that out of this program will come the elimination of that small but undesirable part of health care which is inappropriate, unnecessary and excessively costly. I fear that the program may become a bureaucratic boondoggle in which cost control will supersede interest in quality. I fear that unqualified nonmedical people may end up in the position of trying to determine and dictate what is quality medical care. I fear that inappropriate, arbitrary and authoritative implementation of the program may alienate the health care professionals, both medical and paramedical, to the detriment of the ultimate intended beneficiary of this program, the patient population. I hope that you and your colleagues have the same hopes that I do and will, therefore, do everything possible to prove my fears groundless.

B. It is premature to be able to predict the effect our PSRO will have on the quality of health care in our Area. If the medical community, which in the overwhelming majority is interested in good quality of health care, is really allowed to supervise this program, I believe that it is possible to maintain and improve the quality of health care in our Area.

C. Anticipated Effect on the Cost of Health Care.—There is no question in my mind that poor health care is expensive health care. Even in the instance where initial health care may be expensive, the long term benefit of restoring patients

to productive health, taking them off the welfare rolls, reducing their need for long term care as a result of inadequate short term care and returning them to income producing, tax paying membership in the community, is in the long run a cost savings for us all. This is sometimes overlooked in the short-sighted glance at the high cost of short term health care.

D. Reduction of Overutilization of Facilities.—This question implies that overutilization of facilities exists. We are too new in our operations to have established sufficient data to verify that overutilization does indeed exist. I would assume that if, in the future, we find this to be the case, appropriate monitoring should accomplish the purpose.

### 3. Congressional Hearings on the PSRO Program.

It is my impression that hearings of this type would be premature. They would certainly be costly, probably attract a considerable amount of publicity, but at this stage of the game probably serve no particular useful purpose to the program. The necessary improvements, indicated in my first paragraph, could be brought about without the necessity of Congressional hearings. Right now no one on the PSROs or in the Department of HEW has sufficient experience with the program to be able to offer sufficient constructive and in-depth comments or answers to questions to justify the holding of Congressional hearings.

Thank you for the opportunity of expressing some of my opinions to you. It is good to know that there is a Subcommittee on Oversight which is interested in the program and apparently interested in the reaction of the participating physicians to the program. I too hope that we can work together during the coming months to help insure a successful program.

Sincerely yours,

EARL B. RUBELL, M.D.,  
President.

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PROFESSIONAL STANDARDS REVIEW ORGANIZATION  
OF CALIFORNIA AREA 21 INC.,  
Monrovia, Calif., April 8, 1976.

CHARLES A. VANIK,  
*Chairman, Committee on Ways and Means, U.S. House of Representatives, Subcommittee on Oversight, Washington, D.C.*

GENTLEMEN: Thank you for requesting our input concerning how we feel about the administration of the PSRO program under DHEW; our hopes and fears for the program; and our reaction to the suggestion of a congressional hearing on the PSRO program. We will address each of the questions posed in your letter of March 22 in order.

We should like to preface our comments by stating that they are being written, and should be read, by your committee with the understanding that PSRO is a very new and unique concept, and that an entity as large and complicated as HEW might well have been expected to have difficulties implementing the program. None the less these have been our problems:

(1) The absence of published PSRO regulations has led to the use of "transmittals" which PSRO's are bound by their contracts to accept as law. Frequently the transmittals change a basic portion of our contract, yet we cannot refuse to cooperate. They are lengthy, wordy, unclear, and frequent. Our fear is that PSRO will not be free to function, and may become swamped in paper work.

(2) When we have posed questions requiring quick resolutions, the decision making process is cumbersome and slow. This is probably due to the fragmentation of PSRO authority between BQA and BHI. We feel this could be remedied by having all PSRO activity under one department. Since BHI is under SSA and BQA is under Health Services Administration, one gets the feeling that the left hand doesn't know what the right hand is doing.

(3) It is required that PSRO's accumulate population data and statistics and that HEW was to help by providing what was available. Although we did manage to secure the baseline information, we did not receive any assistance from any federal agency. Surely in the Federal Data Banks there must be population, race and age statistics—also Medicare and Medicaid eligibles.

The local hospitals and medical community have never been notified by HEW that this is an officially contracted PSRO. Consequently, often the response we have received from our contracts has been to either ignore us or question our credibility as an official organization. We have been asking for some time, that

some official notification to area hospitals and health agencies be made, but have not received any support from DHEW in this area.

(4) It has been our experience that frequent personnel turnover occurs in positions in HEW with whom we must relate. We are rarely notified of these changes. We feel that many of these people have little understanding of the program and what their function is meant to be. We question as to whether they get any orientation or indoctrination to their jobs. There sometimes appears to be little communication between the project officer and contract officer in charge of overseeing the work requirements and money requirements respectively of our contract. Obviously those of us in PSRO had little orientation either, but we have had to do our homework carefully to survive.

In the same vein, the IPS training programs (a federal grant) for PSRO personnel lack insight into the level of knowledge of the participants. Consequently much of the material presented is redundant. Much of the time (10 days) is spent ballyhooing PSRO. Participants don't need to be convinced, since they wouldn't be attending an IPS if they were not already involved in the program.

(5) We feel HEW's immediate supervision of the program is too distant. We feel that if project officers had a better conception of the individual PSRO and its operations, there would be improved relations. We have had one visit from our project officer in seven months. We have been told that more authority and direction of PSROs will be moved from Rockville, Maryland to the Regional Offices. This would certainly improve communications.

(6) We do not have problems with reimbursement. The turn around time is about six weeks. We do feel that some of the constraints on the use of contract monies cause inequities. As an example we were given a specific amount of money for Direct Labor. Salaries were approved and we were told that we were allowed 8% for fringe benefits. As it worked out, there was not enough money in that category for us to have anything but *minimum individual* life and hospital insurance. The terms of the contract restricted us from using money from another category where we didn't need it, without modification of the whole contract. Clearly when these contracts were negotiated, neither the PSROs nor HEW were fully aware of what expenses would be, and assigned line item amounts which were either too large or too small. To do any kind of movement of monies, one must go through a mountain of paper work, copies, prior authorization etc.

Although Area 21 is a new PSRO, the physicians and some of the staff involved in it are not newcomers to the area. As you may be aware, the average hospital length-of-stay in California, generally speaking, is less than anywhere else in the country. Although there undoubtedly will be cases of over-utilization which the PSRO will uncover, I don't think it can be assumed that all or even a majority of hospitals in our area are guilty of this. The opportunities for continuing medical education are both available, and are taken advantage of, so medical staffs in Los Angeles in comparison to many areas are quite progressive. For those facilities which are currently not over-utilizing, we do not predict any particular change in length-of-stay under PSRO.

We feel that where over-utilization presently exists, PSRO will curb it, but more significantly we feel that PSRO review will encourage improved *quality* of medical care. Focusing upon quality medical care will be reflected in costs, but this may be in either direction depending upon the situation. Over-utilization is contrary to quality care, but under-utilization is also inappropriate, and PSRO may reveal this too.

It is our hope that PSROs will be allowed to retain a certain degree of autonomy and will not become ineffectual by being choked by paperwork and redundant regulations written by bureaucrats far removed from the real health care delivery system, and perhaps incapable of recognizing the negative impact of some of their data requirements.

It is also hoped that it will be recognized that physicians must be properly reimbursed for their review time. Perhaps one of the reasons the present utilization review program is so resented and poorly conducted, is that physicians are expected to work for free doing utilization review for their hospitals. One never gets a very good job done "for free".

It is also hoped that regional differences will continue to be respected and allowed both in terms of medical criteria and lengths-of-stay. There are many significant factors which account for why a patient in rural northern Minnesota, for example, might not be discharged after a heart attack in the middle of winter, as soon as a similar patient in one of our metropolitan hospitals in Southern

California. (Weather, ease of returning to the facility, transportation, availability of other level of care facilities, etc.).

Here in California we have had direct experience with strict length-of-stay guidelines disregarding medical criteria. The State Department of Health compels hospitals to discharge Medicaid patients according to prescribed numbers of days in an attempt to curb costs. Over and over these prematurely released patients are discharged still sick, and end up being readmitted to the hospital a few days later sicker than ever. The result—a cumulative series of lengths-of-stay for the same patient which is greater and therefore more costly than if the patient had been allowed to remain in the hospital for medically justifiable reasons until ready to be discharged. We feel that this kind of program is medically counter-productive and more expensive to the taxpayer in the long run. We have great fears of the PSRO eventually being coerced into such a system by any future drive for national lengths-of-stay or criteria.

In spite of the fact that our comments appear to be negative or fearful, we would like to re-emphasize that we recognize the program is new and that many of its problems in direction and slowness of progress are a direct result of underfunding. Many planning PSROs were funded and then simply put in a holding pattern while funding problems were being resolved. This led to loss of momentum and to discouragement. We have voiced these same objections and concerns to DHEW and do not expect problems to be resolved overnight.

We feel that it is far too early to even consider hearings on the PSRO program and that such hearings would be both a waste of time and money. I think you would discover that the biggest criticism of the program would be the many planning contracts which have had to literally sit on their hands because of lack of funding to go conditional and were therefore restrained from starting review.

Thank you for considering our comments.

Sincerely,

JOHN SLEETER, M.D.,  
Medical Director.

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AREA 22.  
PROFESSIONAL STANDARDS REVIEW ORGANIZATION,  
Los Angeles, Calif., April 5, 1976.

HON. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight,  
House of Representatives, Washington, D.C.*

DEAR MR. VANIK: Thank you for your letter of March 22, 1976 requesting our views on the PSRO program. You are correct when you describe Area 22 as a relatively new PSRO, but we are happy to report that, though new, we are successful. In four months we enrolled approximately 1,000 physicians into the program, and just recently our plan was fully accepted by the Bureau of Quality Assurance. We were notified that we would be going through notification in May, the only one of the sixteen most recently funded plans to be doing so. For these reasons, then, we feel we are able to comment on PSRO development with validity and insight.

In reference to HEW's administration of the program, we are pleased to report that, on the whole, it has been increasingly enlightened and responsive to the concerns of physicians and generally willing to elicit and accept suggestions and constructive criticisms. Especially useful has been HEW's willingness to circulate drafts of proposed policy for physician comment. (Special kudos for this new approach need to go to the Bureau of Quality Assurance, an office that has developed a good deal of sophistication in a short time.) We understand from those involved longer than we that before this practice started there was a good deal of misunderstanding and conflict between physicians and HEW. We are appreciative of the change in approach, and trust that it will continue and be amplified. There is an increasing need to combine the experience of the practicing physician with the more theoretical approach of the Department.

As for improving HEW's supervision of the program, we would urge less of a concern with detail and process, more of a concern with results. For example, in terms of budgeting, HEW tends to take a rather outmoded line-item approach and, thus, spends a lot of time and energy picking over minor details. Far more productive, perhaps, would be for HEW to identify key budget categories, put a total cost cap (based on experience) on the categories, e.g., direct labor, and then allow the PSRO to divide the pie from there in such a manner that will meet local needs, priorities, and conditions. In such a way overall fiscal responsibility is maintained yet program flexibility is served.

A better exchange of information is also an area for improvement. Right now most PSRO's seem to be dependent on informal, occasional contact with other PSRO's for acquiring useful information. While often surprisingly effective, this approach is also limited in that it is dependent upon the time, energy and willingness of individual PSRO's to go information hunting and in that it often results, through default, in the needless re-invention of the wheel. In short, there is a need for the exchange of information to be systematic rather than occasional and for it to be not dependent on the individual efforts of already over-taxed PSRO's. HEW should take the lead in systematically passing on to PSRO's the useful information it has accumulated about PSRO implementation from PSRO's all over the country. Successfully innovative approaches need to be widely circulated rather than "sat on" by HEW.

Our fears for the program concern its potential bureaucratization, by which we mean the potential siphoning away of local decision-making authority, the slow withering of the concept of HEW/physician partnership, the growth of unilateral determination of the bureaucracy. Physicians need to be given adequate authority and tools to meet their mandated responsibilities. Given this authority, I am confident they will behave honorably, but the authority and tools must first be at hand. Relatedly, it is necessary for Congress to supply adequate resources for program implementation. There exists a substantial fear on the part of physicians that the program will fail and they will be blamed, even though they had little chance to succeed because available resources were inadequate. In addition, there is a need to evidence a basic trust of the good intentions and capabilities of local physicians entrusted with the program. In operational terms, this means an explicit recognition on the part of HEW that a pluralistic approach to program implementation will be more fruitful than a lockstep one. To be flooded with an endless wash of transmittals, directives and sundry restrictions is a draining and psychologically restricting experience. Some of this is no doubt inevitable, but would it not be possible for HEW to consciously seek to move toward a simplification of the program, rather than an endless complexification?

Your questions regarding the effect of PSRO on the cost and quality of health care are, of course, germane, if somewhat speculative. We would guess that PSRO will have a large impact on both areas simply because PSRO replaces fragmented, sporadic approaches with systematic and integrated ones. As importantly, PSRO will inevitably explore the nexus between quality and quantity and make, again systematically, contributions thereby. As PSRO conceptionally and operationally connects problem solving research with fabrication of remedy, there is little chance that discoveries will not be implemented in the day-to-day world of patient treatment.

More specifically in terms of identifying and decreasing excessive utilization, the PSRO approach, on its face, will better focus on utilization because it will replace the present U.R. approach of automatically certifying for 12 and 18 days with a review approach that is diagnosis and age specific and triggered by the 50th percentile of stay, i.e. the time 50% of patients with the specific disease check out of the hospital. As the 50th percentile approach is more precise it will tend to identify those persons who might have automatically stayed in the hospital until the 12 day review time arrived. In addition, PSRO's will be able to identify specific LOS by hospital and disease, establish a LOS norm and direct its attention to LOS permutations from that norm. Should the permutation prove medically unjustified, appropriate action would be taken. This ability to focus on unusual *patterns of treatment* translates into an effective LOS control tool, one far superior to anything now available.

A further reason why PSRO will tend to impact on the problem of overutilization is that it recognizes that health care is of a piece, that acute care is intimately and frequently connected to skilled nursing care and/or home care and that consequently the transition to another level of care needs to be high quality and appropriateness and cost effective. It is unfortunate that because of funding constraints, PSRO has not been able to extend its review reach to at least the skilled nursing home. As a result it has not been able to either effect cost savings at this level or to assure appropriateness of care. Methodologically, a focus on potentially interlocking levels of care is important, as a savings on one level might well yield a cost increase at the next lower level.

A special concern to us in questioning the matter of utilization is the possibility of underutilization. Alleged overutilization has received most of the attention, but we believe the converse needs scrutiny, too. This is especially true

in that HEW has repeatedly pointed out that the problem of quality often mixes with a problem of quantity, that excessive utilization is bad quality care. If true, underutilization is also bad quality of care and it seems reasonable to us that PSRO's, under the aegis of their concern with quality, pursue, document and remedy patterns of underutilization. In this era of cost control, cost control, cost control, the identification of underutilization might seem to border on the irreverent—but it is nonetheless necessary. The controlling purpose of Titles 18 and 19 is, one presumes, to provide medical services to those who qualify, not to save the taxpayer's dollars.

It is not clear from your earlier question about administrative problems whether you were concerned only with internal program problems or whether your concept of administrative was more general. Assuming the latter, I feel compelled to add that the largest impediment to the PSRO program arises from the refractory refusal of related administrative agencies to cooperate with the intent of the law and its implementation. For example, Medicare has fought a tenacious rear-guard battle to maintain its erstwhile if superseded prerogatives. Just recently, it caused to be published proposed UHDA regulations that provided for the utterly redundant collection by the Medicare intermediary of 20% of the data captured by PSRO. The reason: the Medicare bureaucracy did not want to be entirely dependent on PSRO's for data and therefore it sought to preserve its own sources, even though it meant an additional burden on hospital record rooms. This sort of action is bureaucratically typical, of course, and it is clearly in the interest of the particular bureaucracy, but it is a pox upon the taxpayer and a burden to the key program participants.

A more egregious form of bureaucratic recalcitrance is the refusal of the California State Medicaid agency to follow the stated and reaffirmed policy of the Secretary regarding Medicaid agency acceptance of PSRO review decisions. Thus, the State Medicaid review agency, though 90% funded with federal funds, refuses to get out of hospitals that are operating PSRO review systems, and in so refusing is operating a 100% redundant, though not as effective, system. What a waste! Clearly here is an area where effective Congressional oversight is crucial.

In closing, we would like to address your query concerning the possibility of Congressional hearings on PSRO. Absolutely, you should hold hearings—but not now. Wait a year, until the program has been substantially implemented and substantially de-bugged, until a "hard" track record has been established. Then hold hearings, and hold them outside of Washington: PSRO is supposed to be a local program; for Congress to understand it, it must get out to the areas of actual implementation; it must listen to both planning and conditional PSRO's and to practicing physicians involved in both. Additionally, don't exercise Congressional hearing prerogatives unless, in the interim, Congress has actively and forcefully sought to resolve some of the bureaucratic and funding problems currently fettering the program. Finally, we would be very much interested in testifying at any hearings you might hold, even if it means a trip to Washington.

Representative Vanik, we hope you've found these observations useful. If so, we have a request for you. Please send us the name of your staff man who will be examining PSRO. We would like to establish liaison with him and make ourselves available should he have any questions on PSRO or need clarification on any of the above.

We look forward to hearing from you in the near future.

Cordially,

DANIEL A. LANG, M.D.

*Medical Director.*

EDWIN W. BUTLER, M.D.

*President.*

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CALIFORNIA PSRO AREA 23.

*Torrance, Calif., April 26, 1976.*

CHARLES A. VANIK,

*Chairman, Subcommittee on Oversight, Committee on Ways and Means,  
U.S. House of Representatives, Washington, D.C.*

DEAR CHAIRMAN VANIK: In response to your letter of March 22nd, we are gratified that your subcommittee is involving itself so intimately in examination of the PSRO program. It may be premature at this time to try an evaluate the

program as far as objective achievement is concerned, however, the study of techniques of producing regulations and the regulations themselves would probably be productive.

Our greatest problems in developing a Conditional PSRO is to allay the fears of many physicians who are suspicious of the ability of HEW to fulfill the intent of Congress.

HEW and the PSRO's separately find themselves in the position of having to very quickly develop a very complex program with a minimum of precedence for guidance. The lack of precedent produced, in the original regulations, a set of documents which were considered arbitrary and not fundamental to the mission of the PSRO program. However, as time has produced experience, there is a distinct diminution of the apparent arbitrariness. As an example;

An intermediary letter of the DHEW in February 1975 mandated preadmission certification by the PSRO on the staff of the delegated hospital. The medical profession interpreted this as a denigration of its professional status and an implication that most physicians were incompetent or dishonest, or both. Doctors vigorously denied this, and felt that mandated preadmission certification is an attempted solution far worse than the disease, and besides being professionally denigrating, would produce an administrative structure cost far beyond any savings it would effect.

The Secretary of HEW vetoed preadmission certification, but it had the unhappy affect of making physicians in our country a little more gun shy and apprehensive of DHEW's intent.

Federal Register March 30, 1976, has proposed a regulation for pre-elective surgery review. This is probably a reaction to the recent publicity regarding charges of wide spread unnecessary surgery.

I fear that this proposed regulation may be counter productive. It is almost impossible to do real preoperative review when the patient is admitted either one day preoperative, or the day of surgery.

It is likely that the medical staffs attempt to conform to this regulation, will be forced to do an inadequate job for reasons of time. The other possibility is, it would require an earlier admission to a hospital which ultimately will produce an increase in cost.

The same objectives may be accomplished by employing some of the existing techniques of in-house peer review with some constructive modification. Well publicized in-house professionally developed surgical criteria, being used as the basis for post-operative review, will establish patterns of care.

These patterns of care may then indicate that the unusual surgeon requires pre-elective surgery review on an individual basis.

This fear of future centralization has been further compounded by the mandated use of the social security number as an identifier for both patient and physician.

We recognize that the social security number would perhaps add great convenience to the data collection process, but a great risk to the confidentiality of information, and the possibility of production of a national all inclusive file on American citizens. To this date, there has been no substitute proposed for the social security number, but we are hopeful that with the good offices of all concerned, that a numbering system unique to the PSRO be employed, and that the unusual or exceptional physicians or institutions may be readily identified. We believe in the pursuit of this objective, individual cases are important, but that patterns of care should be our primary area of attention, and that out of these patterns will develop the obvious need for improvement in the educational process. We also consider that the police activities by the PSRO should be employed only after the individual physician or institution is proven to be uneducable.

Presently the national direction of the individual PSRO is almost entirely out of the central HEW office by Project Officers and Contract Officers and to much lesser extent, the Regional offices by Associate Project Officers. The Project and Associate Project Officers have proven to be intelligent dedicated people, but distance tends to make their jobs difficult.

It is my understanding that the Regional offices shortly will be assuming more responsibility and am confident that this will be an improvement. PSRO law I believe, has had the effect of improving the quality of care and utilization of services even prior to the incorporation of the PSRO's in an anticipatory way, and these improvements possibly will continue to an irreducible minimum in two or three years, after which it is likely that some Oversight Committee will ask the rhetorical question "What have you done for me lately"?

The excellent acute care institution will probably be unaffected by PSRO. The median and lower quality institutions will undoubtedly improve their services.

It is my belief the area of greatest need, which has thus far received the least attention, is the quality of care in the extended-care facility. Our society is sensitized to the needs of the acutely ill patient, but appears to view the warehousing of our aged in substandard extended-care facilities with equanimity. This is the area where I believe the PSRO can be very productive.

Codification of every facet of human endeavor seems to be the aim of some regulation makers. However, codification alone with strict interpretation leaves no room for compassion or the unusual circumstance. We hope that excessive demands for codification, data retrieval and review will not produce a faceless disinterested bureaucracy.

Congress, I believe, should make the final determination as to the role of the individual State Health Department vis-a-vis PSRO. You may be aware that hospitals are now subject to review by a number of bodies:

1. Joint Commission and Hospital Accreditation;
2. State Health Departments;
3. County Health Departments;
4. Some over view by Comprehensive Planning and its successor HSA; and
5. And others.

The State has expressed its view, since it contributes fifty percent of the Medicaid costs, that it should in effect have a veto power over the actions of the PSRO in the area of Medicaid.

The State of California, in the past, has to a large extent employed parameters of review which have been almost completely economic, and by and large, the physicians of the State of California have felt that these criteria are very much different than the good professional criteria which Congress has mandated should be employed by the PSRO.

We who support the Congress in its legislative intent, feel that a veto power by the State will damage the whole PSRO concept and will further increase our problems and our attempts to recruit physicians to participate in PSRO.

The subcommittee hearings will have available more meaningful information in early 1977, when Conditional PSRO's have been implemented in more areas of the country, and have developed more meaningful statistical review information and the cost experience of performing reviews.

We offer our assistance to you. Please feel free to call on me.

Sincerely yours,

JOHN M. WASSERMAN, M.D.  
Executive Medical Director.

COLORADO FOUNDATION FOR MEDICAL CARE,  
Denver, Colo., May 12, 1976.

Hon. CHARLES A. VANIK,  
Chairman, Subcommittee on Oversight, Committee on Ways and Means, Washington, D.C.

DEAR CONGRESSMAN VANIK: Thank you for your recent letter regarding PSRO Program activities. In response to your first point, we have had very constructive relationships with staff of the B.Q.A. since our designation as a conditional PSRO in July of 1974. Furthermore, BQA has been willing to discuss and alter certain regulations based on input from the Colorado PSRO and other similar organizations throughout the country. In addition, BQA is responsive to constructive criticism and suggestions for innovations to the program.

Much of the confusion in the administration of the PSRO Program on a nationwide basis is attributed to the number of federal agencies that are involved in its administration. This particularly refers to the Social Security Administration's Bureau of Health Insurance and the Social and Rehabilitation Service's Medical Services Administration.

It appears that the BQA is caught in the middle of many bureaucratic battles that hamper its ability to carry out its responsibilities effectively. Therefore, we would suggest that the top administration of H.E.W. direct much of its efforts regarding PSRO towards more effective coordination of all the agencies that have some relationship to PSRO activities.

As we understand, there is a movement to decentralize PSRO authority from BQA to Regional HEW offices. If this organizational activity is to take place, Regional Office staff should be supported with adequate information and clear

lines of authority as to its responsibilities for PSRO's in each respective HEW Region. Otherwise, the administration of the program on a Regional basis will be hampered.

Another concern of ours is the impact of PSRO activities on smaller rural hospitals in our state. In Colorado, some 20 hospitals (of a total 92) account for 65 percent of the combined Medicare and Medicaid admissions in this state. The remaining 72 institutions therefore account for only 35 percent of the Medicare and Medicaid admissions. It appears that much financial and human resources are wasted in having the same kind of review program in such institutions. Furthermore, these smaller rural facilities have rather small medical staffs and a limited number of Medicare/Medicaid admissions on a yearly basis. Perhaps BQA and other federal agencies involved in PSRO should give consideration to changing the review requirements for such facilities.

An additional problem we view is the limited availability of accurate baseline data to effectively evaluate the impact of our PSRO review program efforts. This particularly refers to access to Medicaid data. This problem, in part, was brought out in the Subcommittee on Oversight Investigations of the House Committee on Interstate and Foreign Commerce Report dated January, 1976, near the bottom of page 39. To quote, "... Equally appalling is the lack of adequate data and information necessary to evaluate the Medicaid Program."

One further area of concern is the need to field test specific areas of the PSRO program before implementing certain processes on a nationwide basis. The approach that BQA is taking in the long term care field is a good example of this concern. As we understand, only a limited number of PSRO's will be initially involved in long term care review. We feel this is the right approach to take.

We do not feel that further Congressional hearings on PSRO are necessary at the present time since many issues have recently been reviewed by other bodies of Congress.

By late May, we will be sending you a report regarding cost effectiveness of PSRO review activities in Colorado. Thank you so much for your interest in our program.

Sincerely yours,

DONALD G. DERRY,  
*Executive Vice President.*

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JACKSONVILLE AREA  
PROFESSIONAL STANDARDS REVIEW ORGANIZATION, INC.,  
*Jacksonville, Fla., May 3, 1976.*

HON. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight,  
U.S. House of Representatives, Washington, D.C.*

DEAR MR. VANIK: Thank you for your recent letter on behalf of the Oversight Subcommittee of the Ways and Means Committee regarding that group's examination of the Professional Standards Review Organization (PSRO) program.

The Jacksonville Area PSRO, now in its planning stage, has certain advantages which are apparent in this metropolitan community in areas of peer and utilization review programs already under way. For example, during the past several years, the medical community has supported the concept of a city-wide hospital utilization review committee. Furthermore, the Medical Society and its medical Foundation, have sponsored successful efforts for data collection within the area hospitals, utilizing the CPHA studies (PAS-MAP). Further, the medical community, through its Society and Foundation, have been active in exploring and developing studies and programs in pre-paid health care plans. These endeavors rely on a more organized peer medical utilization review program.

We entered into the planning phase of PSRO in an effort to fulfill the federal requirements and we expect our earlier activities to blend appropriately into the requirements of PL 92-603. As you are aware, medicine has had a continuing concern that, in a program (PSRO) primarily motivated out of cost containment needs, that *quality assurance* might suffer. Organized medicine's intention should be to assure that such does not happen in the PSRO atmosphere.

We are most interested in the recent reports of nation-wide SSA studies on the cost and utilization of services in PSRO areas. (Reference the particular report which was published in the March 22, 1976 issue of AMA News.) We concur with the view expressed therein that the time is too early to weigh the results of that particular survey and certainly any effective evaluation of the PSRO movement in terms of its prime objectives would be premature. The main objective achieved thus far is the *development of a review mechanism.*

It continues to be our hope that the PSRO concept can be as some have termed it, "non-federalized". This is a reference to the PSRO becoming a coordinated review mechanism for service to health insurance companies and other health care type corporations in the pre-paid area. If this can be accomplished, along with the needs of government medicine (Medicare, Medicaid, etc.), such a coordinated area-wide review activity would hopefully only improve on the long-standing practices of medicine in terms of peer review activities.

Finally, Congressman Vanik, we feel that some type of more organized review mechanism is going to be required of the medical profession, by both the public and the private sector for the obvious reasons and that medicine can most appropriately respond and cause the program to be palatable to the *practice* of medicine.

Thank you for your interest. We don't feel that we are deeply enough into our own PSRO experiment to offer any other suggestions for its success. If anything, the mountainous paperwork is the most difficult to digest, even though we appreciate much of the need for reporting information.

Sincerely,

WILLIAM J. GARONI, Jr., M.D.  
*Acting Medical Director.*  
 ROBERT K. MIDDLEKAUFF, M.D.  
*President.*

BAY STATE PSRO INC.,  
 Boston, Mass., May 7, 1976.

Hon. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S.  
 House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN VANIK: In response to your recent letter, the Bay State Professional Standards Review Organization, Inc. offers the following comments relative to the PSRO program.

Basically, it is our feeling that the problems encountered in the implementation of the Bay State PSRO review system have been overcome. Essentially, these problems revolved around two major areas. It was impossible to finalize our requirements for a data processing system until Medicaid data requirements were agreed upon. With the development of a Memorandum of Understanding with the State Medicaid Agency, which was completed on December 1, 1975, and the imminent establishment of a data processing system to support the PSRO program, we expect rapid implementation of the program in the coming months.

We received necessary support from the Bureau of Quality Assurance in solving these problems. It should be noted that both our Project Officer, Mr. Daniel Nickelson, and Director of the Bureau of Quality Assurance, Michael J. Goran, M.D., became directly involved in helping Bay State to resolve the differences with the State Medicaid Agency. Once this Memorandum of Understanding was completed, we were then able to proceed in the final development of requirements for the data processing system. This was done within a fairly rapid time frame and the request for proposal for a data processing system was issued in mid-February, 1976. We expect that the Board of Directors will make a final decision on the selection of a data processor at its meeting scheduled for May 19, 1976. Once this contract is awarded, we expect rapid implementation of the PSRO program for Massachusetts Area IV to begin.

The problem of reimbursement for the costs of delegation appears to be resolving itself with the passage of Public Law 94-182. We are anxiously awaiting the promulgation of regulations in support of those amendments. Many of the hospitals in our area will be much more comfortable in assuming delegated review responsibility once a definitive set of reimbursement rules are established.

Because of the size of the Bay State PSRO, it is virtually impossible to implement PSRO review on a broad scale without data processing support. There are nearly 70 hospitals in our area representing approximately 200,000 Medicaid and Medicare discharges per year. For us to accomplish this without the support of an electronic data processing system would result in a PSRO review system over which we have very little control and very little concrete knowledge of the effectiveness of the overall review process. We would like to caution both the administration and the Congress that PSRO is a new program operating in a relatively complex environment. Although it would be most gratifying to be able to point to the achievement of concrete results either in the area of the measurement or improvement of quality

or dollar savings, such is not possible at the present time. The expectation for such results is, in fact, premature.

To date, Bay State, because of its limited data handling capabilities, has been able to implement five hospitals representing approximately 24,000 Medicare and Medicaid discharges per year. Because of the shortness of time that the program has been in effect, it is extremely difficult to evaluate the effectiveness of review. Although certain prejudgements might be made at the present time, we think it would be a disservice to evaluate the program on that basis even if these prejudgments result in a very positive light for the Bay State PSRO.

We would urge that Bay State, which is a new organization, be given the time to mature and refine its operating systems before a verdict is rendered. It is our belief that the real impact of the PSRO program will be felt once there is sufficient data to allow for valid analysis of patient, physician and institutional profiles. Before such profiles can be developed, the program must be fully operational in the acute care sector for at least one year, if not longer. Because of the size of the Bay State PSRO and the number of Medicare and Medicaid discharges, analysis here is perhaps possible before it may take place in other programs simply because the volume of data here will be greater than in most other PSRO's.

Relative to the possibility of Congressional hearings concerning the PSRO program, Bay State can see no reason why this should not be undertaken. Our organization has been quite visible within the Commonwealth of Massachusetts and I would imagine has been much discussed in Washington being one of the first conditional PSRO's. If Congress is to examine key areas of the program, it is our expectation that the overall operation of the program would be evaluated. On the whole, it is our feeling that the Bureau of Quality Assurance has achieved remarkable success given the limited resources and complex environment in which the program must operate. It is clear that physicians certainly support the program and have expressed not only a willingness, but a strong desire to make it work. Perhaps one of the best approaches for your committee to follow would be to establish, in its own mind, its expectations for the program. Once legitimate objectives are established, the overall achievements of the PSRO program can best be measured over the next five-year period.

Again, we would like to caution that the search for "instantaneous results", while very appealing, may not provide, and probably will not provide, a sound basis for judgments on policy in the intermediate and long term.

If we can be of any further help to you, please do not hesitate to contact us.

Sincerely yours,

GARY M. JANKO, *Executive Director.*

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FEDERATION OF PHYSICIANS  
IN SOUTHEASTERN MICHIGAN,  
*Detroit, Mich., April 22, 1976.*

HON. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee of Ways and Means, U.S.  
House of Representatives, Washington, D.C.*

DEAR MR. VANIK: In response to your letter of March 22, 1976 requesting information pertinent to the development of the PSRO program in our area, we submit the following.

With regard to HEW's supervision of the PSRO program, we are concerned lest the intrusion of the civil service mentality with its "petty bureaucratic tyranny" will, in the long run, stultify innovation in the delivery of health care. We are also fearful that it will result in additional administrative costs to the system. We are very skeptical that in the long run PSRO will be cost effective.

In a more positive vein, we see potential for an areawide application of the historically fragmented operational aspects (as opposed to the planning aspects) of the health care delivery system. This dimension seems to hold promise of identifying and increasing efficiencies in the health care delivery system.

We are also encouraged that the government has sufficient wisdom to recognize that the health care professionals who are responsible for the day-to-day delivery of high quality health care are also in the best position to operate any quality assurance or monitoring programs such as PSRO; but, we think we already detect a solidification of the developmental thinking behind both process

and policy in PSRO, settling into place even before the PSRO's basic premises and assumptions are fully tested.

Your questions regarding the "costs and over-utilization" of facilities must await our answers until our experience permits us to ascertain whether the assumptions of excessive costs and over-utilization which are implicit in the program's planning are justified in our local area.

We are also concerned that the system which has developed a standard of health care which is second to none in the world will be adversely affected by misguided efforts to correct certain preconceived prejudices. We feel that ill-conceived and untested solutions to these preconceived prejudices will be mandated and thus could result in delivering a fatal blow to the system as a whole. We are not all that convinced that costs can or will be reduced.

It is perhaps one thing for an economist to decide that current health care expenditures are too high; but, our patients do not seem to think that any given amount of expenditure is too great. They continually demand the best available physicians, the best treatment techniques, the best facilities, the best medication, and the best equipment, etc. Until the issue of the unlimited desires of the American public for the highest standards in health care is recognized and addressed, we do not believe that costs reductions can occur. Further, given the current inflation rate, cost containment also seems a remote possibility. We are aware that government itself is responsible in no small degree for this inflation.

With regard to our suggestions for improving the supervision of the program, we request that BQA's policy of "prior approval" be stopped immediately. Prior approval is the policy that BQA uses to interpose the contracting office into the day-to-day management decision-making and operational activities of the PSRO organization. This policy requires item by item approval in addition to the contract and negotiation approval process. BQA requires adherence, to this policy, by the contractor even though the total amounts in the contract have been previously negotiated and accepted by BQA. Current interpretation of this policy works so as to require the contracting officer's approval for example, for any personnel hiring, approval of the level of starting salaries, (which are usually judged to be too high without indications of the basis for this prejudgement), approval for each article of equipment purchased and God help you if you want to rent instead of purchasing, approval for such minutiae as the tape cassettes in a dictating unit, approval for travel (even travel less than 50 miles if a state line happens to be crossed), etc. ad nauseam. This interpretation requires multiple written explanations going into great detail. If some detail is missed, typically, the omission is seized upon as an opportunity to either delay response or to respond negatively or more frequently to merely temporize and place pressure on the contractor.

We mention this degree of specificity to give you an indication of the exquisite detail this policy uses in its attempts to usurp our basic management prerogatives and to inform you of the process whereby we are faced with interpretations which are subjective, frequently self-contradicting and always onerous and biased against the contractor. Further, we were told that the intent of the program is to have local autonomy for the medical profession to implement PSRO. Accordingly, we planned and developed Corporate Policies including an estimate of money requirements. The contracting officer then slashed the funds requested with no explanation given for the slashes, or perhaps an indication given that the requested amount is excessive, (but does not offer any criteria for this judgment, other than his subjective opinion). We wonder where, then, is the much heralded local autonomy and flexibility in PSRO that DHEW continues to cite?

Sincerely,

RALPH R. COOPER, M.D.,  
Chairman, Board of Trustees.

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MISSISSIPPI FOUNDATION FOR MEDICAL CARE, INC.,  
Jackson, Miss., April 13, 1976.

HON. CHARLES A. VANIK,  
Chairman, Subcommittee on Oversight,  
U.S. House of Representatives, Washington, D.C.

DEAR MR. VANIK: In the following letter we are replying to your inquiry of March 22, 1976 concerning Professional Standards Review Organizations. To

develop this reply, we have given considerable thought and study to each of your questions and tried to be as objective as possible in answering the questions raised.

The PSRO Program Manual that was issued in 1974 was clear and gave PSROs adequate guidelines for beginning the reviewing program. The level of detail in Chapter VII of the Program Manual gave PSROs needed flexibility in developing their own programs; however, the PSRO Program Manual was incomplete in March of 1974 when it was issued and it is still incomplete in several critical areas. Since that time the policies and procedures governing the PSRO program have been developed and promulgated without reliance on formal rulemaking procedures. For this reason, there have been inconsistencies and obvious contradictions in the policy and procedural statements that have been issued.

PSROs are required to provide the Department of Health, Education, and Welfare with detailed information regarding some aspects of the program, while other important program areas are ignored. The policies and requirements regarding finance and data are so strict that little flexibility is allowed PSROs in program operation and development. Any data that we collect beyond the minimum requirements is closely scrutinized. At the same time, no guidelines have been issued regarding long term care review; however, PSROs are expected to have implemented such a review program in order to be designated as operational.

Policies regarding some aspects of the program, such as the timing of the reconsideration and appeals process, are unrealistic for the setting in which they are supposed to operate. Other requirements are not appropriate for the type of program that we are implementing. For example, the method of contracting is cumbersome and was developed originally for construction type projects which result in the development of a specific product rather than the development of a service to be performed.

Generally, we have had no problem with promptness of reimbursement. There was one period of time during which adequate funds were not deposited in our account. It was necessary for us to obtain a loan in order to meet two payrolls and continue the operation of the program.

DHEW has been slow in reviewing and responding to materials submitted, and in answering specific questions related to program operation and contract renewal. There has been a definite lack of information coming to the individual PSROs regarding review activities in other PSRO areas and the operation of the program at the national level.

We have great respect and appreciation of the knowledge and abilities of some of the Bureau of Quality Assurance staff. We believe that many of the problems that we and BQA are having result from the fact that the PSRO program is so intertwined with old programs whose continuing involvement complicate matters at the Federal level. Responsibilities and functions that formerly belonged with bureaus such as the Bureau of Health Insurance have been separated from them and assigned to the PSROs; yet these functions continue to have impact on these bureaus. The Bureau of Health Insurance failed to do an effective job of review in the Medicare program. Now it appears that the Bureau of Health Insurance will not completely relinquish review responsibilities to the Bureau of Quality Assurance. BQA should be allowed to develop, and the physicians allowed to operate, the review program.

BQA has not been given sufficient funds or authority to effect a smooth initiation of the PSRO program. The resulting problem has been compounded by the lack of official regulations defining program operations.

We suggest that the Department of Health, Education, and Welfare's supervision of the PSRO program could be improved by investing in BQA total responsibility for the PSRO program, and by providing BQA with adequate numbers of staff with expertise in program development and with sufficient funds to administer the program at all levels of operation. Equally important is the necessity that BQA be given the support of higher DHEW levels of administration and the cooperation of related bureaus in the Department. As soon as guidelines for responsibilities can be defined, the delegation of more authority for certain matters to the Regional Office could result in more efficient operation.

In Mississippi the PSRO review program is now operational in 85 hospitals, representing over 8,000 beds with about 10,000 monthly admissions of Medicare, Medicaid, and Maternal and Child Health patients. Since the time that hospital review programs were first approved as binding for payment purposes the hospital care rendered to about 65,000 patients has been reviewed. This represents about a half a million days of care.

It is too early to determine the detailed impact of the PSRO program on the quality, cost, or utilization of health care. The program has created a well defined review mechanism with strong physician involvement and one that is accounting for the inpatient medical care delivered by hospitals to federal health care recipients. Prior to the implementation of PSRO review, there was little knowledge of how federal health care funds were being spent. In Mississippi, the PSRO can account for the inpatient care delivered over the last six months to federal recipients.

We believe that during the first year or two of operation, the PSRO program should be evaluated according to the soundness of the review program and its ability to account for the medical necessity of hospital care delivered, rather than on a measure of cost impact. Although the initial indication is that the average length of stay is lower than in previous years, this measure alone should not determine the effectiveness of the program. The program will be effective when we can show that the Federal health dollar is being spent on quality care for recipients with a need for care.

Specific improvements that have occurred in Mississippi hospitals include more complete physician documentation in the patient record, increased attention to discharge planning, performance of medical care evaluation studies based on identified need rather than on random subjects, and the increased involvement of physicians in the review of patient care.

If Congress holds hearings on the PSRO program, we believe that there are two key issues which should be examined: (1) the delegation of authority and responsibility for the program to BQA and the definition of relationships among the DHEW bureaus; and (2) the maintenance of local physician control of the review program and the delivery of medical care. We must have continued physician involvement in the development and operation of the program and sound, realistic guidelines from DHEW that will allow the necessary control, but sufficient flexibility for effective program operation.

We appreciate your concern regarding the PSRO program and will be glad to work with you and your committee.

Respectfully,

TOM H. MITCHELL, M.D.,  
*Executive Director.*

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PROFESSIONAL STANDARDS REVIEW ORGANIZATION.

IV MOAF, INC.,  
*Springfield, Mo., March 30, 1976.*

Hon. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight,*  
*U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN VANIK: Thank you for your letter of March 22, 1976 and your continuing interest in PSRO operations. First, may I express the opinion of most Area IV physicians. We feel the PSRO program, properly administered, can be worthwhile in improving the quality of medical care in Southwest Missouri and we have voiced this opinion many times, both to the Secretary of Health, Education and Welfare and to the general public.

Second, overall guidelines, regulations and information received from HEW have been generally clear and helpful. MOAF, Inc. has experienced minor delays in voucher reimbursement, but has never encountered severe financial problems as a result of HEW inactivity. My PSRO staff has established excellent lines of communication with HEW in an effort to facilitate a proper exchange of information, while minimizing the flow of unnecessary paperwork.

Third, of real concern to all Southwest Missouri physicians, is the possible loss of local autonomy and input into the PSRO program. Although our area physicians are anxious to work with HEW, with Congress and with representatives of other PSRO's to improve the quality of health care, they would hope to see greater input into the program from *practicing* physicians in all parts of this great country of ours. "Grass roots" input, rather than ivory tower planning and programming, is absolutely essential to making the program viable at local levels and to improve health care to the citizenry.

Finally, we believe the PSRO program will improve both the quality of care and the utilization of health care facilities in this area. As a byproduct of greater utilization, cost containment should result; our immediate goal is quality control.

At the moment, we see no real need for Congressional hearings on the PSRO program. If, however, you elect to hold some hearings at a future date, we hope you will remember that PL 92-603 established a quality assurance program not a cost containment program, and therefore, the success of the PSRO program should not be judged by dollar savings alone.

Thank you for the opportunity of responding to your letter. I hope our input will be useful to you and your committee. Please feel free to call upon us for information and help at any time.

Sincerely,

MICHAEL J. CLARKE, M.D.,  
*Chairman, Board of Directors.*

MONTANA FOUNDATION  
FOR MEDICAL CARE,  
*Helena, Mont., April 20, 1976.*

HON. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, Rayburn House Office Building, Washington, D.C.*

DEAR MR. VANIK: Please accept my apologies for the delay in responding to your recent correspondence.

The Montana Foundation for Medical Care has, up to this point, not experienced an unresolvable difference of opinion with those people we deal with at the Bureau of Quality Assurance. The guidelines have permitted us to function as the Montana Foundation was functioning prior to the PSRO contract. We feel that it is important to contract with HEW on the same basis we contract with other parties. Reimbursement has been for the most part prompt, considering start-up of a new program. Exchange of information was at one time rather difficult but in recent months has been very good. The suggestion which I would have for improving HEW's supervision of the program would be a travel budget to the department not so much for the purposes of audit and investigation, but for an eyeball-to-eyeball confrontation to understand each other's problems better.

It is our opinion that the Foundation and the PSRO are affecting the quality of health care in Montana. At this point, with the limited data available, we do believe we can produce "black vs. white" results; however, we do see many things appearing, some of which are reported to us by hospitals and other parties involved—that is, basically, length of stay is beginning to increase slightly and total patient days are increasing, but there is a very marked reduction in the number of short stays. We are therefore seeing sicker patients in the hospital and, after all, this is the purpose for which we are constituted. It is my personal opinion that at this particular point the PSRO program has not been operational long enough to have produced a change which will be dramatic enough to make an impression on the general public and on many congressmen.

The congressional hearings which you mentioned, in my opinion, should be postponed or not considered at this time; however, I think they possibly should be held two years from now. This would give the PSROs an opportunity of collecting sufficient data to prove their merits.

I appreciate your querying us and hope that we may be able to provide you with the sort of information which would be meaningful to you in your committee activities.

Sincerely,

W. DAVID COYNER,  
*Executive Director.*

CENTRAL NEW JERSEY  
PROFESSIONAL STANDARDS REVIEW ORGANIZATION,  
*East Brunswick, N.J., April 14, 1976.*

HON. CHARLES A. VANIK,  
*Chairman of the Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.*

DEAR SIR: In response to your letter of March 22, 1976, we wish to thank you for your interest in our organization.

As you know, we are a planning PSRO, initially funded in 1975. We expect future funding for conditional status this year, and, to date, we have met all of our anticipated milestones.

The cooperation we have been receiving from DHEW Region II Headquarters in New York, as well as DHEW Central Office has been excellent. Their suggestions have been timely and of a constructive nature.

The goal of our PSRO has been to assist as many as possible of the twenty-two hospitals in our area to achieve delegated review status. Our educational effort has been geared in that direction. In this manner, we feel that we will achieve an improvement in the quality of care rendered in Central New Jersey. It is our opinion that the most efficient use of the health care dollar is the "best care" rendered as early as possible and in the most appropriate setting.

With regard to possible Congressional hearings on the PSRO program, we would welcome your inquiries, comments or suggestions. Funding is the big question with any new program, and we will endeavor to utilize properly all funds allocated to our area.

Again, thank you for your interest. If there is any further information you desire, please contact me at the above address.

Sincerely yours,

MICHAEL J. DOYLE, M.D., *President.*

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SOUTHERN NEW JERSEY,  
PROFESSIONAL STANDARDS REVIEW ORGANIZATION,  
*Cherry Hill, N.J., May 4, 1976.*

Hon. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.*

DEAR SIR: In response to your recent letter, I should like to express first of all, on behalf of the Southern New Jersey Professional Standards Review Organization, Inc., our appreciation of the interest that you show in the P.S.R.O. Program, both nationally and at the local level.

In terms of your general questions in the area of program administration, we think it fair to say that in a program as relatively new and as broad in scope as the P.S.R.O., occasional situations involving guidelines that require further clarification are to be expected. The situation has improved with the adoption of the present procedure by which we may comment on proposed Bureau of Quality Assurance policy according to the same timetable as is the case for regulations published in the Federal Register. Reimbursement for costs incurred in operating under our contract has not posed any major problems. The processing cycle is usually accomplished within one month, and the Paying Office personnel are both reasonable and helpful when questions arise. The major suggestion that we have in this area is the policy of "decentralization" that appears to have already been initiated by the Bureau of Quality Assurance. We look upon this as a step that may have significant potential benefit for this organization, inasmuch as it appears logical to infer that a project officer at the regional level may be more visible and accessible. This is not to suggest that the Central Office staff has been anything less, but it would seem that the possibility of more frequent face-to-face meetings, for example, with H.E.W. project staff, is preferable to the present situation in which most contact is made by the telephone or letter.

The second area of your questions does seem a bit more difficult to address since, as you so accurately state, we are a relatively new P.S.R.O. Our hope, obviously, is that we can implement a comprehensive, integrated system of quality-oriented peer review within the area served by this organization, and that we can maintain a sufficiently close eye on utilization of facilities and services. Based on the nature of the contacts that we and our staff have made within the area, as evidenced by our rapidly-increasing physician membership, we have every reason to believe that this will happen. Our "fear", however, is that interested observers, both within and without Congress, may expect "too much, too soon". The entire program, for various reasons, has not moved as quickly as was hoped at the time of its inception, and it is our impression that most of the conditionally designated P.S.R.O. projects are only now beginning to implement the "P.S.R.O. Review System" in any fashion; delegated, partially delegated, or non-delegated.

Continuing in this discussion of your questions, we in this organization believe that, through a process by which health care is measured by professionals against dynamic, professionally-developed criteria and standards, with problem situations identified and resolved through education, wherever possible, the quality of

health care for the residents of this area will be enhanced. We anticipate that this will be a cooperative effort in which physicians from within the area will interact with all of the Southern New Jersey hospital medical staffs for this purpose. Cost of health care, and its related symptom "over-utilization" will be watched closely by our organization, and it is hoped that through the P.S.R.O. system, optimal utilization of health care facilities will be achieved. As we undertake this part of our program, however, we do it with our professional responsibilities always in mind, which require us to view quality of care as our primary goal. Naturally we expect that the system that we are attempting to develop will eliminate over-utilization, but we intend to implement the system in such a way that quality is enhanced. Cost will obviously be effected by the elimination of over-utilization, but it is, in our case at least, much too early to determine our probable impact, or the duration of the time in which "savings" will occur.

The final area of your questions involves our reaction to the possibility of Congressional hearings on the P.S.R.O. program. We realize full well the need for accountability in all areas of this program. We feel, however, that such inquiries as may be appropriate should take place after the P.S.R.O. program is more fully implemented than is now the case, both nationally and locally.

As was pointed out previously, the system is only now being implemented in anything close to a national scope. The data that will demonstrate the effectiveness of the total program and the individual projects is only now beginning to be accumulated, much less analyzed. We submit, therefore, that Congressional hearings at this juncture seem to be premature, since the program has not had very much chance to document its effectiveness.

In closing, I would like to say that we look forward equally to further contact with the goal of ensuring a successful program.

Sincerely,

HOWARD ZEIDMAN, M.D., *President.*

MEDICAL SOCIETY OF THE COUNTY OF QUEENS, INC.,  
*Forest Hills, N.Y., March 26, 1976.*

HON. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.*

DEAR MR. VANIK: In reply to your letter of March 22, your questions pose several problems particularly to the embryo PSRO program.

Certainly in any new activity regardless of its merits there will be many pros and cons for its procedures. I wonder to what degree there can be frankness in reporting on the questions which you pose. Would any good come out of favorable comments? Would unfavorable comments be accepted without rebound by HEW? In short it is almost difficult for me to see how any clearly objective response can be given to your letter. I, like many others at our community meetings, have ideas. I am sure that some of the ideas that are expressed would raise your eyebrows and those of the HEW hierarchy.

I sincerely hope that PSRO may come up to its expectations but I also hope that it may not turn out to be a top heavy financial burden that will create more problems than it may solve.

Sincerely,

LESTER J. CANDELA, M.D.,  
*Executive Director.*

NORTH DAKOTA HEALTH CARE REVIEW,  
*Bismarck, N. Dak., April 23, 1976.*

CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN VANIK: The Executive Committee requested that I respond to your recent letter regarding the Oversight Subcommittee examination of PSRO programs. Copies of your letter were forwarded to each member of the Board of Directors and their views are expressed in this reply.

This organization is in the planning phase, consequently it is difficult to judge either on the quality of HEW's administration of the program or report on the results which we should be achieving.

It is the opinion of this organization that the PSRO is a viable program and will serve the purpose for which it was intended providing adequate and timely resources are provided. It is paramount that each PSRO be realistically funded to develop and implement a good PSRO program. We must have the resources in order that we can provide a mechanism which will assure quality of care for the beneficiaries of the Title Programs as well as to promote effective, efficient and economical delivery of health services in the State of North Dakota.

We recognize that in the past several years, there have been many technological advances in health care, development of essential sophisticated equipment, new techniques and new skills have greatly increased the cost of health care. These new demands have created a strain on our economic resources. However, it is also our opinion that these improvements in health care are the demands of those being served and an important adjunct for a healthy society and a vigorous nation. We also recognize that it behooves all of us, within as well as from without the medical field, to indicate actions which will conserve costs without jeopardizing the quality and availability of essential health care services.

In our opinion HEW is doing a good job in the development of the PSRO program. It is apparent that they are being hampered from carrying out the mandate of P.L. 92-603 by interference from within Congress as well as from outside sources. From our observation, HEW has not had adequate resources neither manpower or financing at their level to provide these agencies for their planning and conditional status throughout the United States.

*Specifically*, we have had some problems developing our program due to the fact that we do not have all the essential manuals and guidelines. We received nine (9) of the twenty-four (24) chapters to our Operation Manual. We have been advised that the remaining chapters are delayed in being developed due to insufficient manpower. Yet, we who are in the Planning must develop a program without the essential ingredients. HEW has tried to provide us with assistance with Transmittal Letters.

In the future, we recommend that any new programs being considered should not be implemented until the guidelines are published and made available.

To improve the above situation I would suggest that Congress provide sufficient funding in order that HEW has adequate staff to develop and supply the essential guidelines.

*Funding*, this agency is constantly required to prepare written requests to the HEW contract office for items which have been fully substantiated and approved in our formal contract i.e., out of state travel, procurement of equipment, reprogramming within available resources, etc. These restrictions demean and usurp the agencies ability to manage its resources. Suggestion for improving—Once a contract is signed let the agency have the responsibility to manage its resources and be accountable for its actions.

*Secondly*, as an agency in the planning phase we would hope to develop a program which could provide guidance to the physicians and hospitals within our state wherein we could achieve our objectives; to promote effective, efficient, quality and economical delivery of health care services to all the people in North Dakota.

*Fears*, we may not receive adequate funding, program may be delayed due to interference, program is already being evaluated even before we become conditional, whereas, we are just in the planning phase.

*Effect on Quality*, it is foreseeable that the quality of medical care will improve if we are given the time to accomplish this fact. This will not be accomplished overnight, it will take a reasonable time to show results. Quality should be enhanced through the educational program i.e., Medical Care Education (MCE) studies and physician and allied support personnel incentives for continuing education programs.

*Cost effectiveness* may be realized through research, advanced techniques, quicker and better treatment and care thereby using fewer hospitalization days. In addition, written notification to the patient, etc., when maximum hospitalization has been given. This means will serve as a reminder that any further hospitalization is not deemed appropriate and should indicate to the patient that perhaps they are obliged to leave the hospital as soon as possible and free their bed for someone who really needs it.

*Congressional Hearings*, this seems redundant for Congress to hold hearings on the PSRO program at this time. As taxpayers we oppose this action as exceeding what is necessary. To further our position please consider the following information:

(1) The PSRO concept was studied, reviewed, evaluated and determined by Congress as P.L. 92-603 as the route to take.

(2) It is now law of the land—a mandate—why continue spending good American dollars on a program which is just getting started?

(3) There are approximately 65 conditionally designated PSRO's—55 in the planning phase and 92 additional agencies to be programmed—it is most difficult for us to start and continue with a program knowing that it may be either changed or eliminated!

(4) Membership, Board of Directors, and staff lose enthusiasm for a program with all this harassment in Congress!

(5) Hearings—after the fact lead congressional constituents to wonder about their selection as representatives!

(6) The wisdom of holding a hearing now is questionable.

(7) If hearings on PSRO are necessary—Why?

*If Congress holds hearings*—This agency does not feel that hearings are appropriate at this time: In the event a hearing is called, then we feel that Congress should take a positive position and our suggestion would be to assure that adequate financial resources are available in order that we can provide the best program for the welfare of those we serve.

Our statement may seem rather blunt and curt; however, this agency has many reservations about the continual governmental interference and restrictions being placed on medical care and services. We spent a lot of time and money discussing this within the state—medical profession, hospital personnel, legislatures and allied health personages. After several months of discussions, meetings, etc. it was decided to go with the program. When we finally got geared to the program and able to secure assurance from the sources in the state to support this endeavor, the thought of hearings doesn't do much for our enthusiasm!

I guess what we want to tell you is that we are losing our trust in the ability of those in Congress to do their homework before making a public law.

We hope that this letter may be helpful to you and other members of Congress to make a positive decision!

Sincerely,

C. R. MONTZ, M.D., *Secretary.*

UTAH PROFESSIONAL STANDARDS  
REVIEW ORGANIZATION,  
April 5, 1976.

Congressman CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S.  
House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN VANIK: Thank you for your letter of March 22, 1976 in which you pose a variety of questions concerning our operation as a Professional Standards Review Organization. We appreciate the opportunity to respond to your inquiries.

By way of preface, let me say that our overall view of the PSRO program is one of optimism. That attitude is based both on our own experiences here in Utah as well as on the reports of progress we receive from other parts of the country. We believe that program is beginning to demonstrate that it can achieve many of its objectives.

You asked specifically about our relationship with the Department of Health, Education and Welfare. In our view, the Department has done an admirable job of getting the PSRO program up and running. Given the unique nature of the PSRO legislation and the multitude of difficult issues which needed to be resolved, we believe that the Department has done well. Most of our contact has been with the Bureau of Quality Assurance, and we're quite aware that the Bureau's staff has worked long and hard to find reasonable solutions to the complex problems they have faced.

Concerning the effect of our program on the quality of care and utilization of services under Medicare and Medicaid, may I say that we believe we are fulfilling our objective to provide a system of professional accountability for the medical care reimbursed under these government programs. The matter of

evaluating the impact of the review system is most difficult and one that we are not prepared to undertake unilaterally. We have been supportive of DHEW's efforts to construct a valid and meaningful evaluation scheme, and we look forward to an opportunity to participate in its implementation.

In response to your question about the possibility of holding Congressional hearings on the PSRO program, we have an essentially neutral reaction. If the Congress believes that hearings would generate information which is needed currently and which is not available otherwise, then they may be valuable. On the other hand, given the transitional phase in which the program now finds itself with review just commencing in many areas, hearings might be more productive if they were held sometime in the future.

Again, thank you for giving us this opportunity to comment.

Very truly yours,

E. DAVID BUCHANAN,  
Executive Administrator.

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COLONIAL VIRGINIA FOUNDATION  
FOR MEDICAL CARE,  
Norfolk, Va., May 13, 1976.

HON. CHARLES A. VANIK,  
*Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN VANIK: Thank you for your letter of March 22nd inquiring into our experience in the development of PSRO. I apologize for not answering sooner, but our time and staff have been taxed by the necessity of the development of a plan to extend our original one-year planning contract which expires June 28th. This situation was brought about by the passage of Public Law 94-182, requiring the physicians of Virginia, among several other states, to be polled relative to whether they would prefer to have the state redesignated as a single PSRO area. In this instance Congress created more difficulties in our emerging PSRO program than HEW has.

We had developed and submitted to HEW a plan for conditional PSRO designation and have been told by our Project Officer that it meets HEW's requirements. In the meantime we had established a good relationship with our area health care providers, recruited 43% of the physicians as members of the PSRO, and were working closely with the Federal health programs Fiscal Intermediaries in the development of Memoranda of Understanding covering recognition of our review activities, once they started. Now that Congressional action has made the future of this particular organization somewhat cloudy, the momentum of these activities has necessarily been adversely affected. We are appreciative of HEW's recognition and concern for this problem and their offer to continue our support until the pending poll is completed and our future role clarified.

Before responding to your specific questions I would like to note that most of the problems PSROs have with HEW are due to the fact that PSROs conceive of themselves as private foundations contracting with the government to do certain tasks and feel that their internal structure, organization, governing boards, policies relative to their own employees, etc., are their own business and not HEW's concern, as long as contractual obligations are fulfilled timely, at reasonable cost, and with full disclosure of the use of public funds. On the other hand, we can sympathize to some extent with HEW's problem of having to deal with (eventually) 200 odd organizations and some degree of uniformity of structure would make their tasks relative to funding and evaluation somewhat easier. However, the tendency at HEW has been to require the PSROs to comply with guidelines as if they were regulations. The contracting process has been used to force compliance with guidelines and this approach has been somewhat difficult to accept on occasion. We like to think that a softening and slightly more flexible attitude is emerging on the part of the contracting office at HEW. We hope this trend will continue as HEW becomes aware that PSROs are truly dedicated to their roles.

As far as clarity of guidelines is concerned, we certainly have problems at times. It is not always lack of guidelines that bother us as much as the overwhelming verbosity of some of them. The PSRO Manual (guidelines) has not been completed yet, and some of it has been revised by inserting more material.

The missing areas of the Manual, if available, would give us a clearer picture of our future and allow for more effective planning. In the meantime, PSRO Transmittals are issued and these seem to have more rigidity than the Manual, and are, in effect, regulatory edicts. We have recently been given the opportunity to comment on *proposed* Manual and Transmittal drafts prior to their issuance in final form. It would appear that these comments have occasionally resulted in proper revisions before final promulgation. Simpler, cleaner guidelines that are not so rigidly enforced, but flexible enough to accommodate local differences of organization and of approach to problem solving would obviously make the PSRO's lot an easier one and therefore more effective.

We, in this organization, have had no problem with promptness of reimbursement. It is the one area in our relationship with HEW that has given no real problem and any misunderstandings have been promptly and reasonably resolved. HEW has also been cooperative in furnishing information upon request, but little information has been volunteered by HEW. It has been the interchange of information and ideas with our State Support Center and other PSROs and their State Support Centers throughout the country that has been our biggest source of technical data and advice. We are really amazed and deeply impressed that there exists in the United States so many knowledgeable people, physicians, and PSRO executives, dedicated to making the goals of PSRO legislation a reality.

Physicians enter the PSRO program with mixed emotions; a desire to improve the quality of medical care is the only reason any physician support has been generated. The heavy hand of bureaucracy, i.e., overcontrol, is the biggest fear that we have, and the most obvious danger to the program. There is no doubt that HEW needs physician support and cooperation to accomplish quality control. The PSRO program is supposed to be the proper vehicle and we are confident that it will work if physician talent and support is not frittered away on inconsequential matters.

There are so many factors involved in the escalation of health care costs that we are dubious of the effect of PSRO on overall costs. We are certain that PSRO can exert a beneficial influence on overutilization of facilities and in that way one could expect that PSRO will pay its own way. However, costs of drugs, equipment, facilities, operating expenses of institutions, etc., are entirely out of the hands of physicians, and if Congress is looking to PSROs as *the* panacea to the rising costs of health care, then there is bound to be disappointment in the program.

If Congress were to hold hearings to examine the PSRO program, we think the proper key areas to investigate would be:

1. Why haven't HEW's promulgated "guidelines" been treated as suggestions rather than regulations in the development of a PSRO?
2. Has HEW overstepped the intent of the Law by their interference with local PSRO's and Foundations' internal affairs?
3. Can the contracting process be changed to a more flexible arrangement calling for HEW to pay for services rendered by the PSRO?
4. Why hasn't HEW defined the requirements for PSRO conversion from conditionally designated to fully operational status?

Beyond these questions which obviously concern HEW/PSRO relationships, we think it might be appropriate to look into the effectiveness of PSRO review activities on the quality and cost of medical care. Since we have not actually begun review activities it is difficult to point out specific problem areas in this regard, but I suspect that the conditionally designated PSROs in the country would have ideas about the problems of actual review work.

Thank you again for offering this opportunity to comment.

Yours very truly,

ROBERT A. MORTON, M.D.,  
*President and Medical Director.*

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WASHINGTON STATE PROFESSIONAL  
STANDARDS REVIEW ORGANIZATION,  
May 4, 1976.

CHARLES A. VANIK.

*Chairman, Committee on Ways and Means, Committee on Oversight, U.S. House of Representatives, Washington, D.C.*

DEAR MR. VANIK: Your letter inviting comments on PSRO implementation is appreciated.

Before commenting specifically to your inquiry, I should like briefly to discuss the PSRO program here in the State of Washington.

First, we are in a state-wide PSRO with 114 acute care facilities, 465 long-term care facilities, and 5,893 licensed physicians of which 55% are members of the Washington State Professional Standards Review Organization (WSPSRO). Discussions with the Bureau of Quality Assurance leading to our "Conditional" status did take into consideration several unique features to include the following:

1. The Washington State Medical Association has for several years supported development of local autonomous peer review programs and clearly was not interested in supporting a new federal program (PSRO) that had only form and no substance. A meaningful PSRO program had to give equal emphasis to quality assurance and medical audit.

2. Statistically, the state has a very short length of stay, averaging 5.3 days for all admission to short-stay hospitals. For Medicaid the average length of stay is 4.6 days and for Medicare 7.1 days.

In negotiating with HEW for "Conditional" PSRO designation, considerable debate was necessary before agreement could be achieved. This was perhaps natural and a healthy phenomenon as a new and different concept unfolded. BQA had a relatively new staff; as we did, they had far too many proposals and certainly less than adequate funding to support a full-scale PSRO implementation plan.

Our proposal discussed using Local Review Area Physicians (LRAP)—physicians who have expertise in medical audit programs to assist hospital medical staffs in implementing productive quality assurance programs. Doctors have been taught to deliver care . . . not necessarily how to evaluate the delivery of that care. Our fear that every PSRO would be forced into a stereotype model has not materialized. We support the work of BQA and believe our differences have diminished.

Evaluation of PSRO effectiveness is premature and should be carefully done administratively and professionally before the oversight evaluation can be fairly undertaken. We would be happy to assist the Oversight Committee to include testifying if you think it advantageous as we remain supportive of a successful PSRO program.

Respectfully,

TERRY G. KELLEY,  
*Executive Director.*

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